

MRD CHECKLIST

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

Medway Ho	Heart Heart HABH	Patient D Mr. ANANTHA KRISHNA Name: 79/Male/MHI202381290 UHID: 15/12/2023/IPH202302516 DOB: Dr. K. JAISHANKAR DOA:	1HI/IPD/2022/002
The way to bette (A Unit of United Alliance Hea	er health *	ISSION SLIP	Every heart beat count
Admitting Doctor:	In Shark or		
Advised Date & Time:	- K // C3 C	9 pm	
Provisional Diagnosis:	+= \ \	Planomis 2 UTI	CCF.
Reason for Admission:	Medical Management	Surgical Management	
	Others (please specify deta	ails)	
Admission Type:	Day Care ER	 ™Ward	
		(Specify details)	
Surgery / Procedure Name	Medical	maragement.	
Blood Product Requiremen	nt: 🔲 No 🔲 Yes (Kindly spec	cify details of components required in	space below)
Expected Duration of Stay:	3-4 days		
Expected Cost of Treatmer	nt (as per-Financial Counseling Fo	orm):	
Payer: Self Tinsurance	ce Others:		
Instructions to Nurse (if an	v): Adrich	in cov.	
Any other Instructions (if a		· ~	
	Name Outcharka		
Doctor's Signature	Name	Reg. No.	Date Time D

For admission desk staff o	only:		
	General Ward Single Room Twin Sharing Deluxe Room Suite Room Others	V	
Admission intimation	Receipt Details	Admission Ti	me in HIS
Date	Time	Date	Time
18/12/23	12.21.	15/12/23	12:15 PM
To be filled only if Blood	OPD ER Direct requirement specified by the		No
Front office Staff Signature	Name	Emp. No.	Date Time
Sife	Soundary	2209	15/2/23 12:15#



Medway Hospitals®

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



Patient Do Name: UHID: DOB:

DOA:

Mi.Anantha Krishnan.p.n 79/Male/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR

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Medway

MHI/HOSP/2022/129

Consultant: ADMISSION EODM

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Marital Statu Occupation	Full Address AS, SH BAZUL	S HANTHINIKETAW, LAH ROAD, T.	NEW 93, OLD WAGAR, CHENN	42, 91- 600017	Telephone Number 9884684892
Beferred from	m / Dat	te of Time of Admission	Date & Time of Discha	rge Total	No. of Days
DP - Jan	1 F. I	r r			·
) F ()	15	12/2012:15	23/12/23	9 Days.	
UNIT		,		AR No. :	
•	•	FINAL DIAGNO	SIS		ICD Code
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		B , SEVERB			
StEr	ossis, ALL	TE KIDNEY 9	injuly - PECO	OVERED	-
		envin. Noer	-		
4	YPE-JE DO	abres mecin	rus, system	n) c	
Hyl	PEDIT FOLLOW	, BENIAN	prostate	HYPEAPINEIR	•
•					
DATE	1	OPERATION /	PROCEDURES		ICPM Code
		•			
DATE		TYPE OF AN	NESTHESIA		
_	GENERAL	☐ SPINAL	LOCAL	☐ REGIONAL	☐ EPIDURAL
		DISC	HARGE STATUS	-	
□ Cured		☐ Discharge at Requ	uest·	П Б	cpired < 48 hours
│ ─ │ │	ed.	☐ Against Medical A	dvice	_	pired > 48 hours
_ ,		☐ Absconded		_	•
☐ Unchan	gea 	☐ Transferred to			ost-Operative Death
· •	funerast.			e. nla.	Lay
Signature	of the Consultan	t		Signature of Medic	cal Records Officer

AUTHORISATION FOR TREATMENT I PAYMENT

hereby authorise the Administration, Medical and Nursing and Paramedical, Staf f of the Hospital Investigate treat and
administer such drugs as may be necessary and to perform such operation under anaesthesia or other wise as may be
deemed necessary and / or advisable in the diagnosis and treatment of my illness / patient. パ.ハ.カバカバカルバカド よりらけい かん who is my <u>らい</u> (Relationship).
hereby under take to settle all the bills for hospitalisation charges related to me/the patient named overleaf on a periodic

basis. In any case, I shall pay all the dues before getting discharged from the hospital.

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

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

I have read out and explained the contents of the above to the Signatory in his vernacular . சிகீச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

இதன் மூலமாக நான் நீர்வாகம், மருத்துவம், தாதியர், ஏனைய மருத்துவ ஊழியர்கள் எனக்கு / நோயாளிக்கு தேவைப்பட்ட சோதனைகளை செய்து மருந்துகளை கொடுக்கவும். மயக்க மருந்துகள் கொடுத்து செய்முறைகள்/அறுவை சிகீச்சை செய்யவும் அதீகாரம் வழங்குகீறேன். நான் / இதில் குறித்துள்ள நோயாளின் செலவுக்கன தொகை முழுவதும் செலுத்த இதன் மூலம் உறுதி அளிக்கிறேன்.

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

மருத்துவமனையின் பொது சட்ட தீட்டங்கள் பற்றி தெரிவிக்கீப்பட்டிருக்கீறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

செவிலியர் கையொ'பம்

Signature of Admitting Nurse

Date 15/12/2023

எனது/உறவினர்/காப்பாளர் கையொப்பம்

A. Warang

Signature of the Patient / Relative / Gurdian

உறவுமுறை

ANARAMANAN Descrip Nature of Relationship



110

Patient Details (Affix Label here)

Name: MT.ANANTHA KRISHNAN.P.N

UHID: 79/Male/MH1202381290

DOB: 15/12/2023/1PH202302516

DOA: Dr.K.JAISHANKAR

Consultani



GENERAL CONSENT FOR ADMISSION

1	٠ ' ' '	114		1.2
1. Mr. Aroutha Bush	ngan Pahe	☐ Patient or	☐ Representative	of patient have
(please tick the correct option above and belo	(w)			4.14
Read	,	$w_{i,i}$	• • -	, 17 €i J
_				
Been explained this consent form in Engli	sh, which I fully (ınderstand.		
,		** ***		
Laive my full concept and authorization for	or odmionian on	JUSE.	is beenitel. The prop	and treatment
I give my full consent and authorization for	or admission and	u treatigent at tri	із поврікаї. тпе,ргор	osed treatment
plan has been explained to me.	٠,	<i>3</i> • •	7 -	r
			* ** ** ₁	
· I consent and authorize the hospital, tre	ating doctors	nureing technics	al and paramedical	staff to provide
				stail to provide
relevant care and to conduct diagnostic as	raeelijiea lieces	sary by trie treatir	ig doctor/ream.	1 k
•	200	→ Y [*] - (*,*)	i	٠. د
· I also consent to be administered necessar	arv drugs, medic	cations, intravend	ous fluids, as advised	by the treating
doctor/team.	,g., a	, and 110, 111 and 011	, 45 44,100,0	,
doctor, team.				
· lalso consent to use of assistants such as	resident doctors	, other doctors, r	urses, and other hea	Ithcare workers
by the hospital and treating doctor/ team.		indicate cont	•	
- , ,	• •	* *		
	•	:	•	<u>;</u> .
 I consent for clinical consultation, admissi 	on, disclosure of	information requ	iired for clinical mana	igement (under
confidence), routine medical examination	(physical exam	ination, palpation	n, percussion, auscu	Itation), routine
lab and imaging investigations, general nu				
		·	,	, a. 1.5 5 1111 131
		:	¥	
 I have been explained about the propose 	ed care plan, ex	pected result(s),	possible outcome(s	and expected
cost of treatment/ hospital stay.				

- I understand that the hospital will take due care of me / my patient but, that there is always a possibility of an unexpected complication(s) which may necessitate longer stay and / or use of intensive care services. In such cases, procedure different from those contemplated and other intervention(s) may sometimes be needed.
- I declare that, I have and will inform the doctor of my medical history including previous illnesses, allergies, drug reaction(s), surgical procedure, relevant medical family history and all other facts relevant to my treatment. I shall not hold the hospital/doctor responsible for any consequences which may arise due to non-disclosure of relevant information on my part.
- I declare that I have been explained about my rights and responsibilities as a patient as outlined in the patient handbook.
- I have been made aware of the rules and regulations of the hospital including those related to security and I
 promise to abide by them.
- I also consent and agree to the use and/or publication of my treatment details / medical record for medical, scientific or educational purposes (Teaching, research and academics) provided the pictures or the descriptive texts accompanying them do not reveal my identity.

- I understand that in case of some unexpected event occurring during the course of my stay I may be suggested a transfer to another hospital / healthcare organization, as considered appropriate by my treating doctor.
- I understand that, drugs, consumables and devices will be charged on an 'as actual' basis as per the hospital
 tariff. I have been informed and I understand that there can be usage of certain reprocessed items during the
 course of the treatment. I also understand that only full strips of medicines shall be issued and returned. I
 declare that I take full responsibility of settling the bill before leaving the hospital premises at the time of
 discharge.
- I further declare that I have been given an opportunity to ask question(s) related to my admission, care plan and proposed hospital stay, and that such questions have been answered to my satisfaction.
- I also consent to receive communication on treatment related information via text messages and e-mail as per the details provided at the time of registration.
- I declare that I have received and fully understood the information provided in this consent form, that I have been
 given an opportunity to ask questions relating to my admission, care plan and proposed hospital stay, and that
 all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes
 in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my
 presence at the time of my signing this form.
- I, the above-named Patient / named patient's representative, do further hereby declare that I am above 18 years
 of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false
 misconception.

	Signature / Thumb Impression*	Name	Date	Time
Patient	Away	P.N. ANANTHAKRISHNAN	15/12/23	12;15
Surrogate/Guardian (if applicable #)	FOR PATIFAT A:NA KAYANAM (SON)	A·NARAYANAN(SoN) (Write name and relationship with patient)	15/12/20	12:15,
Reason for surrogate consent	Patient is unable to give consent	because:		
Witness	Mary	ANARAYANAN (SON)	15/12/23	12:11
Interpreter (if applicable)	V			

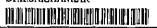
^{*} Right Hand for Males & Left Hand for Females | # Only if Patient is a minor or unable to give consent



Mr.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

S. No.	PARAMETERS	MARK APPROF	
110,		AFTIO	IIIAI E
	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		<u> </u>
	Mean arterial pressure less than 60 mm Hg		
	Diastolic arterial pressure more than 120 mm Hg		
1	Respiratory rate more than 35 breaths/minute		_
	Cardio-vascular System		
	· ·		
	Acute myocardial infarction and 11 d in A 13 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		
	Cardiac tamponade or constriction with hemodynamic instability		
	Dissecting aortic aneurysms		
	Complete heart block		
			
	Miscellaneous Conditions		
	Septic shock with hemodynamic instability		
3	Hemodynamic monitoring		
	Clinical conditions requiring ICU level nursing care		
<u> </u>			
	Post procedure elective admission		
4	Post Coronary Angioplasty		
	Post Cardio-vascular Surgery		
	Following angiographic procedure .		
1	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	<u> </u>	
	Admission at the time of the study is encouraged if problems are suspected or arise		
	Pulmonary System		
Ì	Acute respiratory failure requiring ventilatory support (Invasive / Non-Invasive)		
	Pulmonary emboli with hemodynamic instability		
	Patients in an intermediate care unit (HDU / Recovery room) who are demonstrating respiratory		
6	deterioration		
	Need for nursing / respiratory care not available in such intermediate care units		
	Massive hemoptysis		
	Respiratory failure needing imminent intubation		
	Danalé-Bura		
	Renal failure		
7	Oliguria or anuria for more than 12 hours Metabolic acidosis (pH <7.1)		
	Patients requiring hemodialysis can be performed in ICU when the blood pressure is borderline		
i	Patients requiring nemociarysis carried performed in 1000 when the blood pressure is solderine	ł	

Na.				PARAMETERS			RK ✓ AS OPRIATE		
	Endocrine System and Metabolism related Diabetic ketoacidosis complicated by hemodynamic instability, altered mental status, respiratory insufficiency, or severe acidosis								
Thyroid storm or myxedema coma with hemodynamic instability Hyperosmolar state with coma and/or hemodynamic instability or Serum Glucose more than 800 mg/dl									
8		nypercaicemia i ynamic monitoring		sum more than 15 mg/di) with alter	ed memai status, requ	iring			
		hypernatremia (S		m less than 110 mEq/L or more than 155	mEq/L) with seizures, alt	ered			
ĺ				odynamic compromise or dysrhythmias					
ł		rhyperkalemia (Si arweakness	erum Potassi	um less than 2.0 mEq/L or more than 6.0	mEq/L) with dysrhythmia	as or			
		nosphatemia with	muscularwe	akness		- 			
		Signature	<u> </u>	Name	Reg. No.	Date	Time		
_	Doctor			Dr. Anish Nelson	Dr. Anish Nelson		12:30		
Do	CfOL	1				11731173 <i>113</i>			
		CHARGE	CRITE	Reg. No: 88434	Reg. No: 88434				
s.			CRITE	Reg. No: 88434		MAF	RK,√ AS		
S. No.	DIS	CHARGE	ameters	Reg. No: 88434 RIA FOR INTENSIVE PARAMETERS	CARE UNIT	MAF	RK,√ AS		
S. No. 1	DIS Stable r	CHARGE	ameters Pt. extubated	Reg. No: 88434 RIA FOR INTENSIVE PARAMETERS d with stable arterial blood gases) & airwa	CARE UNIT	MAF	RK,√ AS		
S. No. 1 2 3	DIS Stable r Stable r Minima	CHARGE nemodynamic parespiratory status of loxygen requirem	ameters Pt. extubated ent (not more	Reg. No: 88434 RIA FOR INTENSIVE PARAMETERS d with stable arterial blood gases) & airway e than 3 L by nasal prongs)	E CARE UNIT	MAF	RK,√ AS		
S. No. 1 2 3 4	Stable r Stable r Minima Intraver	charge nemodynamic par espiratory status of loxygen requirem nous / Inotropic / V	ameters Pt. extubated ent (not more	Reg. No: 88434 RIA FOR INTENSIVE PARAMETERS d with stable arterial blood gases) & airwa	E CARE UNIT	MAF	RK,√ AS		
S. No. 1 2 3	Stable r Stable r Minima Intraver Cardiac	CHARGE nemodynamic parespiratory status of loxygen requirem	ameters Pt. extubated ent (not more	Reg. No: 88434 RIA FOR INTENSIVE PARAMETERS d with stable arterial blood gases) & airway e than 3 L by nasal prongs)	E CARE UNIT	MAF	RK,√ AS		
S. No. 1 2 3 4 5 6 7	Stable r Stable r Stable r Minima Intraver Cardiac Present	nemodynamic par espiratory status of loxygen requirem rous / Inotropic / V dysrhythmias are ce of distal pulses s of bleeding and	ameters Pt. extubater ent (not mon asopressors controlled	Reg. No: 88434 RIA FOR INTENSIVE PARAMETERS d with stable arterial blood gases) & airway e than 3 L by nasal prongs) support and vasodilators are no longer no	E CARE UNIT	MAF	RK,√ AS		
S. No. 1 2 3 4 5 5 6	Stable r Stable r Stable r Minima Intraver Cardiac Present	nemodynamic par espiratory status loxygen requirem nous / Inotropic / V dysrhythmias are ce of distal pulses s of bleeding and fe care pathway c	ameters Pt. extubater ent (not mon asopressors controlled	Reg. No: 88434 RIA FOR INTENSIVE PARAMETERS d with stable arterial blood gases) & airway e than 3 L by nasal prongs) support and vasodilators are no longer no	E CARE UNIT	MAF APPR	RK ✓ AS ØPRIATE		
S. No. 1 2 3 4 5 6 7 8	Stable r Stable r Stable r Minima Intraver Cardiac Present	nemodynamic par espiratory status of loxygen requirem rous / Inotropic / V dysrhythmias are ce of distal pulses s of bleeding and	ameters Pt. extubater ent (not mon asopressors controlled	Reg. No: 88434 RIA FOR INTENSIVE PARAMETERS d with stable arterial blood gases) & airway e than 3 L by nasal prongs) support and vasodilators are no longer no	E CARE UNIT	MAF	RK AS ØPRIATE		







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

: 15/12/2023

: 23/12/2023

D.O.A

D.O.D

Room No. : 110.

DISCHARGE SUMMARY

IP No.

IPH202302516

UHID

MHI202381290

Name

Mr. ANANTHA KRISHNAN.P.N

Age / Gender

79Years / MALE

Consultant

: Dr.JAISHANKAR.K MD., DM., FIAMS

Director and Clinical Lead

Cardiology and Electrophysiology

AGNOSIS:

PATOMEGALY ASCITES - ? CHRONIC LIVER DISEASE

SEVERE CALCIFIC AORTIC STENOSIS

ACUTE KIDNEY INJURY - RECOVERED

THROMBOCYTOPENIA

NORMAL LV FUNCTION

TYPE II DIABETES MELLITUS

SYSTEMIC HYPERTENSION

BENIGN PROSTATIC HYPERPLASIA

PRIEF HISTORY:

Mr. Anantha Krishnan. P.N, 79 years / Male, Presented with complaints of shortness of breath on and off for 2 days.h/o bilateral lower limb swelling and mild abdominal pain ,h/o loss of appetite and generalized tiredness. He came to Medway heart institute ER on 15.12.2023 and he was advised to admit for evaluation and further management.

No H/O Syncope or presyncope.

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

N/K/C/O Hypothyroidism, CVA, BA, seizure disorder.

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

HR

104pm

BP

140/80mmHg

 SPO_2

94%

CVS

S1S2 (+) A2 elevated

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

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94457 94457 1800 572 3003

Medway Group of Hospitals

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Medway Centre of Excellence (Chennai)

Kodambakkam 044-2473 4455 04

Mogappair 044-26530011 Kumbakonam 044-2473 4455

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

MHI/HOSP/2022/118





THA KRISHNAN.P.N

UHID: MHI202381290

Heart Institute

12® асстерте мавнасстерви AE B/L Basal crepts

Abdomen - distension+, Liver & spleen palpable +

CNS - NFND

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

INVESTIGATIONS:

BLOOD(14.12.2023): Hb- 11.6gm/dl, TWC- 4690cells/cumm, PLT – 100000 cells/cumm, Urea – 28 mg/dl, Creatinine – 1.78 mg/dl, Na+ – 130Meq/l, K+ - 4.09meq/l, SGOT – 88U/L, SGPT – 35U/L.

<u>BLOOD(15.12.2023)</u>: TWC-75,000cells/cumm, Urea – 33 mg/dl, Creatinine – 1.63 mg/dl, NT pro BNP – 102, PT – 15.4secs, INR – 1.2 secs.

BLOOD(16.12.2023): Hb- 10.7gm/dl, TWC- 4700cells/cumm, PLT – 80000cells/cumm, Urea – 31 mg/dl, Creatinine – 1.61mg/dl, Na+ – 130Meq/l, K+ - 3.71meq/l, SGOT – 66U/L, SGPT – 34U/L. Alpha feto protein – 2.26IU/mL. ammonia – 60, albumin(ascitic fluid) – 1.8g/dL, proteins (ascitic fluid) – 4.5

BLOOD(17.12.2023): PLT - 85,000cells/cumm, TWC- 13950cells/cumm, Albumin - 3.5g/dL

<u>ELOOD(18.12.2023)</u>: Hb- 10.4gm/dl, PLT – 90000 cells/cumm, Urea – 56 mg/dl, Creatinine – 2.07mg/dl, Na+ – 135Meg/l, K+ - 3.62meg/l, SGOT – 74U/L, SGPT – 27U/L.

BLOOD(20.12.2023): Hb- 11.9gm/dl, PLT – 151000 cells/cumm, TWBC – 7450 cells/cumm, Urea – 87 mg/dl, Creatinine – 1.83mg/dl, Na+ – 136Meq/l, K+ - 3.69meq/l.

<u>BLOOD(21.12.2023)</u>: Hb- 12.8gm/dl, TWBC – 7180 cells/cumm, Urea – 84 mg/dl, Creatinine – 1.59 mg/dl, Na+ – 137Meq/l, K+ - 3.67meq/l, aPTT – 79.7 secs, INR – 1.5 secs.

BLOOD(21.12.2023): Hb- 12.1gm/dl, Urea – 88 mg/dl, Creatinine – 1.45 mg/dl, Na+ – 134Meq/l, K+ – 3.64meq/l.

ECG: HR – 65bpm, long QT interval

CXR(14.12.2023): Mild cardiomegaly. Bilateral mildly increased bronchovascular markings.

SCREENING ECHO (14.12.2023): Thickened and calcified aortic valve. Severe AS. Max gradient – 70mmHg, mean gradient – 41mmHg. AV Vmax – 4.1m/sec. No AR. Trivial MR. Trivial TR. Mild PAH. Concentric LVH. No RWMA. Normal LV systolic function. EF – 60%. Normal RV systolic function. No clot / vegetation / effusion.

<u>USG abdomen(14.12.2023):</u> Liver parenchymal disease. Splenomegaly. Prostatomegaly. Moderate ascites. Minimal right pleural effusion.

Peripheral smear(15.12.2023) - Thrombocytopenia

Urine culture & sensitivity(15.12.2023): Few pus cells and no bacteria seen. no growth in culture.

Stool-occult blood(19.12.2023)- Negative

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 $\textbf{E-mail}: info@medwayhospitals.com \mid \textbf{CIN}: \textbf{U74900TN2011PTC083665}$



UHID: MHI202381290



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Mr. Anantha Krishnan.P.N, 79 years / Male, admitted with above mentioned complaints in CCU Baseline investigations were done which showed increased total counts and Creatinine level Alexipheral transcriptes sent which revealed thrombocytopenia. USG abdomen showed splenomegaly, prostatomegaly, minimal bilateral pleural effusion, moderate ascites, liver parenchymal disease. Echo showed normal LV function. Due to abdominal pain & splenomegaly Dr. Karthik (medical gastroenterologist) opinion was obtained & he adviced for ODG scopy. Ascitic tapping was done & sample sent for ascitic fluid analysis. Patient improved symptomatically & shifted to ward on 18.12.2023 with CBD insitu (+). Due to complaints of black coloured stools, stools occult blood sample sent which showed negative. Patient voided freely & CBD removal. Due to breathlessness, drowsy, disorentation to place & time patient shifted to ICU on 20.12.2023. ABG done. Due to severe bilateral crepts, nebulisation started. Then patient symptomatically improved. Patient was treated with IV fluids, IV diuretics, IV antibioties, analgesics, anti-pyretics, beta blockers & other supportive measures. He symptomatically improved with above line of treatment. His medications were optimized and discharged in a stable clinical condition.

CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile

General condition Stable

GCS

15/15

Temp PR 98.6°F 82/min BP

SPO₂

100/84mmHg

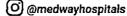
96% in room air

ADVICE MEDICATIONS

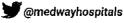
1	SI.	NAME OF THE DRUGS	DOSAGE	FREQ	UENC	Υ	ROUTE	RELATION	DURATION
	NO	WITH GENERIC NAME	, <u>L</u>	M	Α	N		SHIP WITH MEAL	
	1.	TAB. ALDACTONE (SPIRONOLACTONE)	25 MG	1 '	, 0	0	ORAL	AFTER FOOD	TO CONTINUE
	2.	TAB. DYTOR (TORASEMIDE)	.10 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
	3.	TAB. INDERAL (PROPRANOLOL)	20 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
	4.	TAB. SILODAL	8 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
•	5.	TAB. UDILIV (URSODEOXYCHOLIC ACID)	30 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE

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							Everen la	eart beat counts
6.	TAB. NUSAM	200 MG	1	0	0	ORAL		TO CONTINUE d Alliance Healthcare Pvt Ltd)
7.	TAB. NAC	600 MG	1	0	1	ORAL	AFTER FOOD	X 3 DAYS
8.	TAB. UDILIV (URSODEOXYCHOLIC ACID)	30 MG	I	0	1	ORAL	AFTER FOOD	TO CONTINUE
9.	SYP. LACTIHEP	15 ML	I	0	1	ORAL	AFTER FOOD	TO CONTINUE
10.	TAB. RCIFAX (RIFAXIMIN)	550 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
11.	TAB. PROSTAGARD	8 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
12.	INHALER.LEVOLIN	0.63 MG	1	1	1	P/N	TO CO	NTINUE
13.	INHALER.FORACORT	0.5MG	1	0	1	P/N	TO CO	NTINUE
14.	TAB. PAN (PANTOPRAZOLE)	40 MG	1	0	0	ORAL	BEFORE FOOD	TO CONTINUE

Г	Sl.	NAME OF THE DRUGS WITH	DOSAGE	FREQ	FREQUENCY		ROUTE	RELATION	DURATION
	NO	GENERIC NAME		M	Α	N		SHIP WITH MEAL	
\perp			_						
	15.	TAB. TENEGLIP M	20/50 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
-									

	DISCHARGE ADVICE						
DIET	LOW FAT , SALT & DIABETIC DIET.						
PHYSICAL ACTIVITIES	AS TOLERATED						
REVIEW	REVIEW WITH DR. JAISHANKAR.K AFTER 2 WEEKS WITH BLOOD SUGARS, CBC, RFT, LFT REPORTS.						

If temp > 101 'F / Difficulty in breathing / chest pain / Giddiness/ palpitations. Any other significant symptoms. In case of emergency Contact: Medway Hospitals @ 4310 8959.

> "I understood the Content of the discharge summary."

可yped by: Ezhilarasi.

CONSULTANT SIGNATURE

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

: Shall

Dr. K. JAISHANKAR Reg. No: 49448

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Mogappair

044-26530011

Kodambakkam

044-2473 4455

044-2473 4455

04146-242000

MHI/HOSP/2022/118





Mr.Anantha Krishnan.p.n

79/Male/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





INPATIENT INITIAL ASSESSMENT

Date: 15 12 23. Time of	arrival in ward: 2.15.
Allergies (if Yes, specify details):	
Drugs ☐ Yes ☐ Yo	
Blood Transfusion ☐ Yes ☐ Ño	
Food	
Others	·
Vital Signs: Temp: 97.1 (°F) Pulse / HR: 10.4 (beats/mir Respiration: 3♥ (breaths/min) SpO₂: 9′1 (%) Height: 1	
Pain: Yes No. If Yes, Score: Oho, Pain Scale Used: Numerical Rating Scale (>12 years) Duration: Location:	CPOT (ventilator / comatose)
Pain Character: Dull Aching Sharp Stabbing S	nooting Burning Referred / Radiant Pain
CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS	
PANGUR AND SINNERNIERS OF BROWN	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
IN CHANSON OVER THE CASE W	354
CAME GOR MITZ - DENGWYT	o premiruous nuo - so somano iname
Rus BINGNOSINO ADIMIC CARA	NSIS. (SPRIME)
PAST MEDICAL HISTORY (with duration of illness):	
Diabetes Mellitus: Yes \(\subseteq No. \) If Yes, duration: Hype	rtension: Lives LINo. If Yes, duration:
Others: BPH	
Past Surgical History:	
	- ,
	1
	·

Present Medication (for Medication Reconciliation):									
S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay			
	Gener 2		Pi	1-0-0	Agleil ron	☐ Yes ☐ No			
$\frac{1}{2}$	7001CO4 M		Py	0-0-1	Bulr	☑Yes □ No			
3	Prosimamo	Gny	Pm	0-0-1	7	☐ Yes ☐ No			
4	ur maxx	6 m ₀ → γ							
5	115-0 coopsul		Per		,	☑ Yes □ No			
				1		☐ Yes ☐ No			
☐ Yes ☐ No									
						☐ Yes ☐ No			
	-					☐ Yes ☐ No			
			,			☐ Yes ☐ No			
Life	sonal / Social History (Tick whice	Occup	ation:						
	noking: Yes No Alcoho hers:	ol:	□ No	Recreationa —	l Drug Use: ☐ Yes ☐ I	No			
Men	strual and Obstetric History (to	be filled uր	o for fema	le patients):					
	N/A								
	eneral Physical Examination								
Pallor: ☐ Yes ☐ No									
Mup people thorang									

SYSTEMIC EXAMINATION
cvs:
Sh ()
<u></u>
Respiratory System:
oze wingeps / Bu moningen
Gastrointestinal System:
Sie Di Simolio
Y
ntral Nervous System:
NANO
Urinary / Reproductive / Locomotor System:
$\sim\sim$
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:
Ng tional 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 ☐ Nø
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: STENENT MISTAL STENDERS ! CO
om on 1 BPH
Plan of Care: SMADIWZA
INJuen FOR TANI TEMILINES
In Juin GAR DE PER - C185

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Investigations Ad	lvised:		_		į		
Nypiwa	orper CXR.				•	·]	
PUCASE	couper CXR.						
						-(
Diet Advice:	·						
☐ Nil per Oral	Clear liquid diet	☐ Normal liqui	d diet	☐ Diabetic I	iquid diet		
Semisolid diet	☐ Soft solid diet	South Indian	normal diet	☐ North Ind	ian normal c	liet	
☐ Neutropenic liquid	diet					_	
Early Discharge Plan	ning (fill in those which are	appropriate at thi	s stage):	PFE: Pa	tient Family l	Education	
Special support need	led at home	∠ Yes □ No	If Yes, PFI	E done			
Home equipment ant	☑ Yes ☐ No	If Yes, PFE done and equipment advised					
Physiotherapy at hon	ne anticipated	☐ Yes ☐ No	If Yes, educated on physical limitations, if any				
Wound care needs a	nticipated at home	Ø Yes □ No	If Yes, educated on signs on infection				
Pain Management		Yes □ No	If Yes, PFE done and medication advised				
Special Dietary needs	S	Yes □ No	If Yes, educated on dietary restrictions, food drug interactions and allergies				
Continuous / ongoino	g care anticipated	☑ Yes □ No	If Yes, educated on various aspects of ongoin care required				
Other special educat	ion need, i.e.:	☑Yes ☐ No	If Yes, PFE done				
Nature of post hospit infection control, fall	al needs like patient safety, risk, etc, addressed	☑ Yes □ No	If Yes, specific education given				
Others:							
				-		\	
	Signature	Name	-	Reg. No.	Date	Time	
Resident Doctor	June D	— Dr. Anish Nels Reg. No: 884		DDAMelsNelson RReg. No: 88484	15 12 23	19.25	
Consultant	1 2 sicher	10R-JA	ISH ANGUN	1844	15/12/25	12,25	
Patient Attendant	AWWE	Relationship Sor			15/12/22	1225	
	J. U		- -	,			



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Mr.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/iPH202302516

Dr.K.JAISHANKAR





CONSENT FORM FOR CRITICAL CARE (ICU)

i, The Patient of Prepared to be patient at the prepared to th
above and below):
√ Read
have been explained in detail by the treating doctor and I understand about the condition of me / and my patient or my
patient's illness and I am aware of the all the possible outcomes.
Been explained this consent form in English / TAMIL., which I fully understand and understood the information
provided about ICU Treatment
I acknowledge that, I had the opportunity to discuss with the doctor about the condition of myself or my patient, treatment options, procedures needed to improve the patient's condition. I hereby give consent to treat the illness of myself or my patient and to do emergency procedures like Endotracheal Intubation including other methods of securing airway, mechanical ventilation, central venous access, arterial lines and further
methods of monitoring which are needed to improve or treat my condition.

CENTRAL VENOUS CATHETER INSERTION

Brief description of the Procedure:

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

Intended benefits:

Common reasons for having a central line include:

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

Possible risks and complications:

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

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

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

Alternative Forms of Treatment: Peripheral Venous Access

ENDOTRACHEAL INTUBATION

Brief description of the Procedure:

Endotracheal Intubation is often an emergency procedure that's performed on people who are unconscious or who can't breathe on their own. Endotracheal Intubation maintains an open airway and helps prevent suffocation. A flexible plastic tube is placed into your / your patient's trachea through the mouth to help you breathe. The trachea, also known as the windpipe, is a tube that carries oxygen to the lungs.

The size of the breathing tube is matched to the age and throat size. The tube is kept in place by a small cutf of air that inflates around the tube after it is inserted. The trachea begins just below the larynx, or voice box, and extends down behind the breastbone, or sternum. Trachea then divides and becomes two smaller tubes: the right and left main bronchi. Each tube connects to one of the lungs. The bronchi then continue to divide into smaller and smaller air passages within the lung. The trachea is made up of tough cartilage, muscle, and connective tissue. Its lining is composed of smooth tissue. Each time you / your patient breathes in, the windpipe gets slightly longer and wider. It returns to its relaxed size as you breathe out. You can have difficulty breathing or may not be able to breathe at all if any path along the airway is blocked or damaged. This is when Endotracheal Intubation can be necessary. Endotracheal Intubation keeps your airway open. This allows oxygen to pass freely to and from your lungs as you breathe.

Intended benefits:

The procedure might be needed for you/your patient for any of the following reasons:

- · to open airways so that patient can receive anaesthesia, medication, or oxygen
- to protect your / your patient's lungs
- · when patient has stopped breathing or is having difficulty breathing
- when patient needs help to breathe
- · when patient has a head injury and cannot breathe on his/her own
- · when patient needs to be sedated for a period of time in order to recover from a serious injury or illness

Possible risks and complications:

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

Possible alternatives:

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

I am now aware of the intended benefits, possible risks and complications, and available alternatives to the said procedure. I am also aware that results of any procedure can vary from patient to patient; and I declare that no guarantees have been made to me regarding success of this procedure. I am aware that while majority of patients have an uneventful prosedure and recovery, few cases may be associated with complications. I am aware of the common risks and complications associated with this procedure as listed above, and understand that it is not possible to list all possible risks and complications of any procedure.

For the above-mentioned procedures that I have been made aware of, I give my consent voluntarily to doctor for carrying out the said procedure on myself or my above-named patient being fully aware of the nature, potential risks and complications, intended benefits and possible alternatives.

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

	Signature / Thumb Impression*	Name	Date	Time
Patient				,
Surrogate/Guardian (if applicable #)	J. Wang	A-NALAYANA (Gon) (Write name and relationship with patient)	15/12/23.	12.30
Reason for surrogate consent	Patient is unable to give consent because:			
Witness	P.B. Publica	p.B. Subbalakohin	15/12/23	12.30
Interpreter (if applicable)				

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

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

	Signature	Name	Reg. No.	Date	Time	
Doctor	Low	Dr. Anish Nelson Reg. No: 88434	Dr. Anish Nelson Reg. No: 88434	15/12/10	(Di36).	



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



உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

	என்ற	பெயர் கொண்	ட ப நோ	யாளியா	ன அல்	லது 🛭	ு நோயாளியின்	பிரதிநிதி	யான		
நான்,	இந்த	ஒத்திசைவு பட	டிவத்தை	(மேலே	மற்றும்	கழே	உள்ளவற்றில்	சரியான	விருப்பத்தேர்வை	தயவுசெய்து	ışæ
செய்க)											

🗆 வாசித்திருக்கிறேன்

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

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

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

மைய சிரையில் கதீட்டர் உட்செருகல்

மருத்துவ செயல்முறையின் சுருக்க விவரணை:

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

அடைய திட்டமிடப்படும் பலன்கள்:

மைய லைனை பொருத்துவதற்கான பொது காரணங்களுள் கீழ்க்கண்டவை உள்ளடங்கும்:

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

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

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

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

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

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அணுகுவசதி

மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல்

மருத்துவ செயல்முறையின் சுருக்கமான விவரணை:

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

கவாசிப்பதற்கான இந்த குழாயின் அளவு நோயாளியின் வயது மற்றும் தொண்டை அளவிற்குப் பொருத்தமானதாக தேர்வு செய்யப்படும். உட்செலுத்தப்பட்டதற்குப் பிறகு குழாயை சுற்றி விரிவடைகின்ற காற்றின் ஒரு சிறிய சுற்றுப்பட்டையின் மூலம் உட்செலுத்தப்பட்ட குழாய் அதே இடத்தில் இருக்குமாறு வைக்கப்படும். முச்சுக்குழாய், குரல்வலைக்கு சற்றுக்கு தொடங்குகிறது மற்றும் மார்பு ஒலும்பிற்கு பின்னே வரை அது நீள்கிறது. அதன்பிறகு முச்சுக்குழாய் இரு சிறு குழல்களாக பிரிகிறது: வலது மற்றும் இடது பிரதான முச்சு சிறுகுழாய்கள் ஒவ்வொரு நின்றேயிருக்கிறது. இடைது பிரதான முச்சு சிறுகுழாய்கள் ஒவ்வொரு முற்கும்பிற்கு இனைக்கப்பட்டிருக்கிறது. இந்த முச்சு சிறுகுழாய்கள் அதன்பிறுகு நுறையீரலோடு இணைக்கப்பட்டிருக்கிறது. இந்த முச்சு சிறுகுழாய் அதன்பிறுக்கு ஆன் முற்றும் பாறைகளாக தொடர்ந்து பிரிகின்றன. முச்சுக்குழாய் என்பது, கடினமான குருத்தெலும்பு, தசை மற்றும் இணைக்குப்குதிக ஆகியவற்றால் உருவானது. இதன் அகவுறை மிருதுவான திசுக்களால் ஆனது. ஒவ்வொரு முறையும் நீங்கள் / உங்களது நோயாளி காற்றை உள்ளே சுவாசிக்கும்போது மூச்சுக்குழாய் சற்றே நீளமானதாக மற்றும் விரிவானதாக ஆகிறது. மூச்சை வெளியே விடும்போது அதன் முந்தைய தளர்வான நிலைக்கு அது திரும்புகிறது. மூச்சுப்பாதையில் எந்தவொரு இடமும் சேதமடைந்திருக்குமானால் அல்லது தடை பட்டிருக்குமானால் உங்களால் சுவாசிக்க இயலாமல் போகலாம் அல்லது கவாசிப்பதில் சிரமம் இருக்கலாம். இத்தகைய தருணத்தில் தான் மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல் அவசியமாக இருக்கக்கடும். இந்த செயல்முறை உங்களது மூச்சு / காற்றுப்பாதையை அடைப்பின்றி திறந்த நிலையில் வைக்கிறது. நீங்கள் சுவாசிக்கும்போது உங்களது நுரையீரலிலிருந்து மற்றும் நுரையீரலுக்கு ஆக்சிஜன் தடையின்றி, தாருளமாக சென்று வகுவதை இது அனுமதிக்கிறது.

அடையத் திட்டமிடப்பட்டுள்ள பலன்கள்:

கீழ்வரும் ஏதாவதொரு காரணத்திற்காக இந்த மருத்துவ செயல்முறை உங்களுக்கு /உங்களது நோயாவிக்குத் தேவைப்படக்கூடும்:

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

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

- பற்கள் அல்லது பற்கட்டமைப்பிற்கு காயம்
- தொண்டை அல்லது மூச்சுக்குழாயில் காயம்
- இரத்தக்கசிவ
- நுரையீரல் சிக்கல்கள் அல்லது காயம்
- உறிஞ்சி வெளியிழுத்தல் (லயிற்றிலுள்ள உணவுப்போருட்களும், அமிலங்களும் நுரையீரல்களில் சேர்ந்திருக்கும்போது)
- பிற இடர்கள் (ஏதும் இருக்குமானால்):

சாத்தியமுள்ள மாற்று வழிமுறைகள்:

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

மேற்குறிப்பிடப்பட்ட மருத்துவ செயல்முறையின் மூலம் அடைய திட்டமிடப்பட்டுள்ள பலன்கள், சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள், இந்த செயல்முறைக்கு கிடைக்கக்கூடிய பீற மாற்று வழிமுறைகள் பற்றி இப்போது நான் அறிந்திருக்கிறேன். எந்தவொரு மருத்துவ செயல்முறையிலும் அதன் முடிவுகள் நோயாளிக்கு நோயாளி வறுபடக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன்; மற்றும் இந்த மருத்துவ செயல்முறையின் வெற்றி குறித்து எனக்கு எந்தவித உத்திறகாதங்களும் அளிக்கப்படவில்லை என்பதையும் நான் உறுத்பிட தெரிவித்துக்கொள்கிறேன். பெரும்பான்மையான நோயாளிகளுக்கு அசம்பாவிதம் இல்லாமல் அறுவகிக்கை மற்றும் மீண்டு குணமடைதல் நிகழ்கின்ற நேர்வில், சில நேர்வுகளில் சிக்கல்களை ஏற்படக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன். மேல குறிப்பிடப்பட்டுள்ள இந்த மருத்துவ செயல்முறையிலும் ஏற்பட சாத்தியமுள்ள ஆபத்துகள் மற்றும் சிக்கல்கள் அனைத்தையும் பட்டியலிட சாத்தியமில்லை என்பதையும் நான் புரிந்துகொள்கிறேன்.

இந்த மருத்துவ செயல்முறையின் தன்மை மற்றும் சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள் மற்றும் உத்தேசிக்கப்படும் நன்மைகள் மற்றும் சாத்தியமுள்ள மாற்றுமுறைகள் பற்றி நான் அல்லது மேலே பெயர் குறிப்பிடப்பட்டுள்ள எனது நோயாளி முழுமையாக அறிந்திருக்கும் நிலையில் எனக்கு விளக்கப்பட்ட மேற்கண்ட மருத்துவ செயல்முறைக்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை நான் அளிக்கிறேன்.

மேலே பெயர் குறிப்பிடப்பட்டுள்ள நோயாளியான /நோயாளியின் பிரதிநிதியான நான், இப்படிவத்தில் கையொப்பமிடும் தேதியில் 18 ஆண்டுகள் வயதுக்கு மேற்பட்ட, சீரான நல்ல மனநலம் கொண்ட நபராக இருக்கிறேன் மற்றும் எந்தவித அச்சம், அச்சுறுத்தல் அல்லது தவறான கண்ணோட்டம் இல்லாமல் இச்செயல்முறைக்கு

-	கையொப்பம் / கட்டைவிரல் ரேகை	பெயர்	தேதி	நேரம்
தோயாளி				
பதிலாள் / பாதுகாவலர்			-	
(பொருந்துமாணல் [#])	•	(டெயர் & நோயாளிக்கு என்ன உறவமுறை என்பதை எழுதவும்)		
	நோயாளியால் ஓப்புதல் வழங்க இயலவில்கை			
பதிலாள் ஒப்புதல் வழங்குவதற்கு காரணம்				
சாட்சி				
மொழிபெயர்ப்பாளர்				
(பொருந்துமானால்)				

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

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

	கையொப்பம்	பெயர்	பதிவு எண்.	தேதி	நேரம்
மருத்துவர்					
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Mr.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





PROCEDURAL CONSENT FORM

l acknowledge that :	l acknowledge that:									
The treating doctor has explained my medical condition and the proposed procedure(s)										
(name of procedure(s)	Asc	BUL TURPONE	<u>د.</u>							
I understand the risks / complications of the procedure, including the risks / complications that arre specific to										
me, which are as follows			<u>, V</u>							
✓ The doctor has explain	ned the benefits, pro	bable outcomes and reasons	for the procedure	•						
✓ The doctor has explain	ined other alternati	ve treatment options and the	ir associated risks	s. The doctor has						
also explained my pro	gnosis and the risks	of not having the procedure p	erformed.							
✓ I was able to ask que	estions and raise co	oncerns with the doctor abou	at my condition, th	e procedure, the						
associated risks, and	I my treatment opt	ions. My questions and cor	ncerns have beer	considered and						
answered to the fulles	t of my satisfaction.									
✓ The doctor has explain	ned to me that if imm	nediate life-threatening events	s happen during th	e procedure, they						
will be treated accordi										
	• •	ous illness, drug reactions, su	• .							
		he hospital or the Doctor resp	onsible for the cor	isequence, which						
may arise from the nor	n-disclosure of the s	ame.								
KINDLY FILL EITHER:										
Consent of Patient,	•									
Consent of patient r	epresentative / surr	rogate								
CONSENT OF PATIEN	T									
On the basis of above st	atements,									
I hereby authorize Dr.	KARTHIK RAS	a	nd those that he/s	he may designate						
as associates or assistar	its to perform upon	me the stated diagnostic / the	erapeutic procedu	re.						
	Signature	Name	Date	Time						
Patient										
Witness / Interpreter	Jalant	A-NARAYAN AN (SON)	16/12/23.	16.50						
Doctor	1/2	Dr. Muthon 16/10/29 16:50								

ANAESTHESIA / SED	ATION requirem	ent						
Required Not Required								
I give consent and agree	e to the administrat	ion of anaesthesia / sedatio	n by Dr					
	for th	e performance of this proce	dure. I am aware o	of the risks of the				
sedation and also conse	nt supplementation	n with any other mode of an	aesthesia if necess	sary.				
	Signature	Name	Date	Time				
Patient								
Witness / Interpreter								
Doctor		-						
CONSENT OF PATIE	NT REPRESENTA	ATIVE / SURROGATE						
The patient is unable to o	consent because _		and I,					
name / relationship to th	e patient), therefor	e consent for the patient. I a	acknowledge that I	have had an				
opportunity to discuss th	opportunity to discuss this procedure, as stated above, with the doctor / doctor's designee and hereby							
1 1	is procedure, as sig	ated above, with the doctor.	/ doctor's designee	and hereby				
	·	ated above, with the doctor	/ doctor's designee	and hereby				
consent to this procedure	·	ated above, with the doctor	/ doctor's designee	and hereby				
consent to this procedure	·	Name	/ doctor's designee	and hereby Time				
Patient	э.	-		·				
-	э.	-		·				
Patient	э.	-		·				
Patient Witness / Interpreter Doctor	e. Signature	-		·				
Patient Witness / Interpreter Doctor The patient is unable to	Signature consent because	-	Date	Time				
Patient Witness / Interpreter Doctor The patient is unable to name / relationship to the second content is the second content is the second content in the	consent because	Name ore consent for the patient.	Date I acknowledge the	Time and I				
Patient Witness / Interpreter Doctor The patient is unable to (name / relationship to to popportunity to discuss an	consent because	Name ore consent for the patient. on, with the doctor / doctor	Date I acknowledge the	Time and I				
Patient Witness / Interpreter Doctor The patient is unable to (name / relationship to to popportunity to discuss an	consent because	Name ore consent for the patient. on, with the doctor / doctor	Date I acknowledge the	Time and I				
Patient Witness / Interpreter Doctor The patient is unable to (name / relationship to to popportunity to discuss an	consent because	Name ore consent for the patient. on, with the doctor / doctor	Date I acknowledge the	Time and I				
Patient Witness / Interpreter Doctor The patient is unable to (name / relationship to to popportunity to discuss an	consent because he patient), therefor	Name ore consent for the patient on, with the doctor / doctor	Date I acknowledge the designee and here.	and I at I have had ar ereby consent to				
Witness / Interpreter Doctor The patient is unable to (name / relationship to to poportunity to discuss an anaesthesia / sedation	consent because he patient), therefor	Name ore consent for the patient on, with the doctor / doctor	Date I acknowledge the designee and here.	and I at I have had ar ereby consent to				



Heart Institute
Every heart beat counts

மருத்துவ செயல்முறைக்கான ஒப்புதல் படிவம்

				(மருத்துவ செயல்முறைகளி
		ப்பட்டுள்ளவாறு எனக்கு குறிப்:		/ சிக்கல்கள் உட்பட, இந்த
<u> </u>	ழக்கூடிய இடர்கள் / சிக்கல்க	ளை நான் புரிந்து கொண்டுள்வே	ளன்.	
✓ இந்த மருத்துவ செ விளக்கிக் கூறியிருக்	- -	தியமுள்ள விளைவுகள் மற்றும்	ற் இதை செய்வதற்கான கார ல	னங்களை மருத்துவர்
	றையை மேற்கொள்ளாவிட்டால்	அவைகளோடு தொடர்புடைய இ ஏற்படக்கூடிய இடர்கள் குறித்		
✓ எனது நோய் நிலை, கேள்விகள் கேட்கவு	் சிகிச்சைமுறை மற்றும் அத ம் மற்றும் கவலைகளை தெரி	ன் இடர்கள் மற்றும் எனது சிக் விக்கவும் முடிந்தது. எனது சே	கள்விகள் மற்றும் கவலைகள்	
🗸 மருத்துவ செயல்மு	றையின்போது உயிருக்கு அச்ச	னிக்குமாறு அவைகளுக்கு பத் ஈறுத்தலான உடனடி நிகழ்வுகள விளங்கிக் கூறியிருக்கிறார் ம	ள் ஏதும் நிகழுமானால், அவை	
 ✓ என்னுடைய முந்தை தொடர்பான அனைத் 	து பிற உண்மைகளையும் நா	எதிர்வினைகள், அறுவைசிகிச் என் மருத்துவரிடம் தெரிவித்துள் மனையையும் மற்றும் மருத்து	ர்ளேன். இவற்றை நான் வெளி	ப்படுத்தாமலிருந்தால்
தயவுசெய்து இவற்றுள் ஒன்ற நோயாளியின் ஒப்புதல் அல் நோயாளியின் பிரதிநிதி / பத்	லது			
நோயாளியின் ஒப்புதல் மேற்கண்ட அறிக்கைகள் / தக	எவல்களின் அடிப்படையில்			
இங்கு குறிப்பிடப்பட்டுள்ள நே		ன மருத்துவ செயல்முறையை அவள் பணி ஒதுக்கீடு செய்ய	•	ு அல்லது
உதவியாளர்களுக்கு நான் இ	தன் வழியாக அங்கீகாரம் அஎ	ிக்கிறேன்.		
	கையொப்பும்	பெயர்	தேதி	நேரம்
நோபாளி				
சாட்சி /			-	
மொழிபெயர்ப்பாளர்				
மருத்துவர்				

□ தேவைப்படுகிறது □ தேவை	ப்படாது			
, - ,	-			
மருந்து / உணர்விழப்பு மருந்	ு மேற்கொள்ளப்படுவதற்கு டாக் து தரப்படுவதற்கு நான் சம்மதி நக்கிறேன். அவசியமானால், மய	க்கிறேன் மற்றும் ஒப்புத	ல வழங்குகிறேன். மயக்க மரு வேறுபிற வழிமுறைகளின் மூல	அவர்களால் எனக்கு மயக்க நந்து / உணர்விழப்பு மருந்தின் ம் ஆதரவு வழங்கப்படுவதற்கும்
	கையொப்பம்	பெயர்	தேதி	நேரம்
நோயாளி				
சாட்சி / மொழிபெயர்ப்பாளர்			- 	
மருத்துவர்		-		
என்ற நான், நோயாளிக்காக மருத்துவரால் நியமனம் செய்	ஒப்புதலை வழங்குகிறேன். பேப்பட்ட நபரோடு கலந்து பே முறைக்கு ஒப்புதலை வழங்குகி	மலே குறிப்பிடப்பட்டுள்ள சுவதற்கு எனக்கு வாய்ப்பு றேன்.	இந்த மருத்துவ செயல்முன இருந்தது என்று நான் ஒப்ப	ர் / நோயாளிக்கு உறவுமுறை) ந குறித்து மருத்துவருடன் / புக்கொள்கிறேன் மற்றும் இதன்
நோயாளி	கையொப்பம்	பெயர்	தேதி	நேரம்
opnianos.				
சாட்சி / மொழிபெயர்ப்பாளர்				
மருத்துவர்		-		
என்ற நான், நோயாளிக்காக மருத்துவருடன் / மருத்துவராள	ஒப்புதலை வழங்குகிறேன். பே	மலே குறிப்பிடப்பட்டுள்ள ராடு கலந்து பேசுவதற்கு	மயக்க மருந்து / உணர்விழ ் எனக்கு வாப்ப்பு இருந்தது எ	ர் / நோயாளிக்கு உறவுமுறை) ப்பு மருந்து வழங்குவது பற்றி என்று நான் ஒப்புக்கொள்கிறேன் நேரம்
நோயாளி	_	<u> </u>		· ·
சாட்சி: / மொழிபெயர்ப்பானர்	-		-	
மருத்துவர்			 	

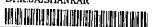


(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.ANANTHA KRISHNAN.P.N

79/Male/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





INFORMED CONSENT FOR PHYSICAL RESTRAINT

	explained the current clinical condition	nt or Pepresentative of patient have (please n of me/my patient I fully understand and understood the infor							
Physical Restraint									
Indications for Restraint :									
Types of Restraint	: Extremity (Ankle or Wrist) [☐ Boxer ☐ Elbow restraint ☐ others :							
BRIEF OFTHE PRO	OCEDURE								
patient's body that the	individual cannot remove easily which	or mechanical device, material, or equipment restricts freedom of moment or normal acces	ss to one's body	cent to the					
		ention of injury to others 3, others (if any spe	cify): ` ,						
Potential Risks & C		<i>:</i>							
ability to ambulance in		uscle tone 4, Loss of Balance 5, Loss of declining independence, dignity and self-respect 7, Dep							
Potential Alternative		, 1		. "					
I declare that I have opportunity to ask q alternatives, potentia my entire satisfaction	The patient may require chemical restraint, kindly discuss with your doctor 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 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 signing this form.								
above named patient to above named F	peing fully aware of the nature, potentian Patient / named patient's representative	re of, I give my consent voluntarily for carrying il risks and complication, intended benefits an , do further hereby declare that I am about 18 sent without any fear, threat or false misconce	d possible altenati years of age as o	ives,					
Cate or signing this to	Signature / Thumb Impression*	Name	Date	Time					
Patient	1								
Surrogate/Guardian (if applicable #) ANALMAN (Son) (Write name and relationship with patient)									
Patient is unable to give consent because: Reason for surrogate consent									
Witness	p.B. Swin	p. p. Subbalakulmi	17/12/23.	13.40,					
Interpreter (if applicable)									
* Right Hand for Males &	Left Hand for Females # Only if Patie	nt is a minor or unable to give consent							



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Patient Details (Affix Label here)	
Name:	
UHID:	į

Sex:



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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	an I.e
confident that he / she has understood the information fully as described in this document.	

								-		
	Signature)	Name	Name			No.		Date	Time
Consent obtained by				L	_					
	PH	IYSICAL RES	L RESTRAINT VITAL SIGNS							
Date & Time	In right position	CRT <3 Sec yes/No	Skin intact	Temp (f)	Pulses (rate/ min)	Resp (rate/ min)	BP (mm/ Hg)	SpO2	Releasing of restraint 2nd hourly	Sign
F1223/1370			*-	98 'E	74	28	12/	94	2 mhour	8gm
15:00	-			98.F	₹6	රු	130 150	96	2rd hard	Sh
16:00				97.8	68	26	130	76%	200	8
17.00				048	Lo_	27	128	C47.	2501	Solv
18.00				Gr. 8	Ťı	26	四百	97	mul	al .
19.00				GIR	72	24	195 165	97	5000	- Sell_
\$0,00.				98F	88	80	3015	98	8 pl	2
00'12	,,			98.	78	88	影	99	2 industry	8
22:00				<i>186</i>	80	26	130/12	loor	2rd	& THE
J.87.00			_	986	Sã	38	100	dd-1.	pleaser!	S
00:00	-			98F	772	36	138	loa!	Wenn Bre	Q.
Note : vital sign	- ns for ICU pa	atients will be	monitored in th	e ICU flo	w chart	· -			-	05
Complications:	ye	es 🔲	No (If yes, speci	ify the syr	nptoms)					
Impaired	Skin integrity		Cyanosis			Pallo	r			
Cold and	clammy skin		Tingling sensation	 1	-	Num	bness			
Injury or t	fall due to resti	raint	Increased confus	ion / Agitat	ion / Disorie	ntation				
Others			2						-	



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- Detient Deteils	(Affix Label bara)	
Patient Details	s (Affix Label here)	
Name:		
UHID:		
DOB:	Sex:	
'		



Every heart beat counts

உடல் சார்ந்த தடுப்புக்காப்புகளுக்கு தகவலறிந்து வழங்கும் ஒப்புதல்

	என்ற பெயர் கொண்ட ்ட நோயாளியான அல்லது ்ட நோயாளியின் பிரதிநிதியான
செய்க)	நான், இந்த ஒத்திசைவு படிவத்தை (மேலே மற்றும் கீழே உ ள்ளவற்றில் சரியான விருப்பத்தேர்வை தயவுசெய்து டிச்
நான் முழுமையாகப் புரிந்த	ின் தற்போதைய மருத்துவ நிலைமை பற்றி எனக்கு / எங்களுக்கு விளக்கிக் கூறப்பட்டிருக்கிறது. து கொள்கின்ற தமிழ் மொழியில் இந்த ஒப்புதல் படிவம் விளக்கப்பட்டிருக்கிறது மற்றும் செய்யப்படவுள்ள மருத்துவ – தகவலை நான் புரிந்து கொண்டிருக்கிறேன்.
உடல்சார்ந்த தடுப்புக்காப்பு	
6டுப்புக்காப்புக்கான நோய் ச	கட்டிக்காட்டல்கள் :
6டுப்புக்காப்பின் வகைகள்: 🗆	ு கால் கை முனைகள் (கணுக்கால் அல்லது மணிக்கட்டு) 🗆 பாக்ஸர் 🗆 முழங்கை தடுப்புக்காப்பு 🗖 பிற :
செயல்முறையின் விளக்கம் 'உடல் சார்ந்த தடுப்புக்க கட்டுப்படுத்துகின்ற மற்றும் ரந்தவொரு கைத்திறன் சார்ர்	காப்புகள்" என்பது, நகர்விற்கான சுதந்திரத்தை அல்லது ஒருவரது உடலிற்கான இயல்பான அணுகுவசதி ஒரு நபரால் எளிதாக அகற்ற இயலாதவாறு நோயாளியின் உடலோடு அல்லது உடலுக்கு அருகே இணைக்கப்ப ந்த வழிமுறை அல்லது பொருள் சார்ந்த அல்லது பொறியியல் சார்ந்த கருவி, பொருள் அல்லது சாதனத்தைக் குறிக்கு
டத்தேசிக்கப்படும் பலன்கள்	т: 1, சுயகாயம் ஏற்படாமல் தடுப்பது 2, பிறருக்கு காயம் ஏற்படாமல் தடுப்பது 3, மற்றவை (ஏதும் இருக்குமானால் குறிப்பிடு
அல்லது நடமாடும் திறன் கு	றும் சிக்கல்கள்: 1 அதிகரிக்கும் 2, சருமத்தில் சிராய்ப்பு / கிழிசல் 3, தசையின் வலுயிழப்பு 4, சமநிலைத்திறன் இழப்பு 5, தனியாக நகரும் நறைதல் & அதிகரிக்கும் பிதற்றல் 6, சுதந்திரம், கண்ணியம் மற்றும் சுயமரியாதை இழப்பு 7, மனச்சோர்வு, சஞ்சலம், நறைந்திருக்கும் சமூகத்தொடர்பு 9, மற்றவை (ஏதும் இருக்குமானால், குறிப்பிடுக):
இந்த ஒத்திசைவு படிவத்தி பாதிப்பு, செய்யப்படுகின்ற சாத்தியமுள்ள சிக்கல்கள்	புக்காப்பு தேவைப்படலாம்; உங்களது மருத்துவரோடு இது பற்றி தயவுசெப்து கலந்து பேசவும். ல் கொடுக்கப்பட்டுள்ள தகவலை நான் கிடைக்கப்பெற்றேன் & முற்றிலும் புரிந்துகொண்டேன் என்றும், எனது நே அறுவைசிகிச்சை / மருத்துவ செயல்முறை, அதன் இடர்வாய்ப்புகள், பின்விளைவுகள், மாற்று வழிமுறைக மற்றும் உத்தேசிக்கப்படும் பலன்கள் மற்றும் மீண்டு குணமடைதல் தொடர்பான கேள்விகள் கேட்பதற்கு எனக்கு எ என்றும் மற்றும் நான் முழு திருப்தியடையும் வகையில் என்றுடைய அனைத்து கேள்விகளுக்கும் பதிலளிக்கப்பட்ட
ான்றும் மற்றும் என்னுடைய மேலும் இந்த படிவத்தில் நா எனது முன்னிலையிலேயே பூ நான் அறியுமாறு விளக்கப்ப இந்த மருத்துவ செயல்முறை	மனதில் தவறான அபிப்பிராயங்கள் அல்லது பொய்யான நம்பிக்கைகள் இல்லை என்றும் நான் உறுதிமொழி சுறுகிறோ ான் கையொப்பமிடும்போது, இந்த படிவத்தில் சேர்க்க வேண்டிய அல்லது பூர்த்திசெய்ய வேண்டிய அனைத்து பகுதிகளு பூர்த்தி செய்யப்பட்டன என்றும் நான் உறுதிமொழி சுறுகிறேன். பூட்ட, மேலே குறிப்பிடப்பட்டுள்ள மருத்துவ செயல்முறைகளுக்கு மேலே பெயர் குறிப்பிடப்பட்டுள்ள நோயாளியான நா அமை மேற்கொள்வதற்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை தருகிறேன் மற்றும் இதன் தன்மை, வாய்ப்புள்ள இடர்ச சிக்கப்படும் பலன்கள் மற்றும் சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்று நான் முழுமையாக அறிந்திருக்கிறேன்.
என்றும் மற்றும் என்னுடைய மேலும் இந்த படிவத்தில் நா எனது முன்னினலயிலேயே பு நான் அறியுமாறு விளக்கப்ப இந்த மருத்துவ செயல்முறை ஏற்றும் சிக்கல்கள், உத்தேசி மேலே பெபர் குறிப்பிடப்பட் வயதுக்கு மேற்பட்ட, சீரான	ான் கைபொப்பமிடும்போது, இந்த படிவத்தில் சேர்க்க வேண்டிய அல்லது பூர்த்திசெய்ய வேண்டிய அனைத்து பகுதிக்கு பூர்த்தி செய்யப்பட்டன என்றும் நான் உறுதிமோழி சுறுகிறேன். பட்ட, மேலே குறிப்பிடப்பட்டுள்ள மருத்துவ செயல்முறைகளுக்கு மேலே பெயர் குறிப்பிடப்பட்டுள்ள நோயாளியான நா றமை மேற்கொள்வதற்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை தருகிறேன் மற்றும் இதன் தன்மை, வாய்ப்புள்ள இடர்ச
ன்றும் மற்றும் என்னுடைய மேலும் இந்த படிவத்தில் நா எது முன்னிலையிலேயே பு நான் அறியுமாறு விளக்கப்ப இந்த மருத்துவ செயல்முறை ந்றும் சிக்கல்கள், உத்தேசி மலே பெபர் குறிப்பிடப்பட் பயதுக்கு மேற்பட்ட, சீரான	ான் கைபொப்பமிடும்போது, இந்த படிவத்தில் சேர்க்க வேண்டிய அல்லது பூர்த்திசெய்ய வேண்டிய அனைத்து பகுதிக்கு பூர்த்தி செய்யப்பட்டன என்றும் நான் உறுதிமோழி சுறுகிறேன். பட்ட, மேலே குறிப்பிடப்பட்டுள்ள மருத்துவ செயல்முறைகளுக்கு மேலே பெயர் குறிப்பிடப்பட்டுள்ள நோயாளியான நா றபை மேற்கொள்வதற்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை தருகிறேன் மற்றும் இதன் தன்மை, வாய்ப்புள்ள இடர்ச சிக்கப்படும் பலன்கள் மற்றும் சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்றி நான் முமுமையாக அறிந்திருக்கிறேன். ட்டுள்ள நோயாளியான / நோயாளியின் பிரதிரிதியான நான், இப்படிவத்தில் கையொப்பமிடும் தேதியில் 18 ஆண்டுச் நல்ல மனநலம் கொண்ட நபராக இருக்கிறேன் மற்றும் எந்தவித அச்சம், அச்சுறுத்தல் அல்லது தவறான கண்ணோட்
என்றும் மற்றும் என்னுடைய மேலும் இந்த படிவத்தில் நா எனது முன்னினலயிலேயே பூ நான் அறியுமாறு விளக்கப்ப இந்த மருத்துவ செயல்முறை றற்றும் சிக்கல்கள், உத்தேசி மேலே பெயர் குறிப்பிடப்பட் வயதுக்கு மேற்பட்ட, சீரான இல்லாமல் இச்செயல்முறைக் நோயாளி	ான் கையொப்பமிடும்போது, இந்த படிவத்தில் சேர்க்க வேண்டிய அல்லது பூர்த்திசெய்ய வேண்டிய அனைத்து பகுதிகளு பூர்த்தி செய்யப்பட்டன என்றும் நான் உறுதிமோழி சுறுகிறேன். பட்ட, மேலே குறிப்பீடப்பட்டுள்ள மருத்துவ செயல்முறைகளுக்கு மேலே பெயர் குறிப்பிடப்பட்டுள்ள நோயாளியான நா றுயை மேற்கொள்வதற்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை தருகிறேன் மற்றும் இதன் தன்மை, வாய்ப்புள்ள இடர்ச சிக்கப்படும் பலன்கள் மற்றும் சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்றி நான் முமுமையாக அறிந்திருக்கிறேன். ட்டுள்ள நோயாளியான / நோயாளியின் பிரதிநிதியான நான், இப்படிவத்தில் கையொப்பமிடும் தேதியில் 18 ஆண்டுவ நல்ல மனநலம் கொண்ட நபராக இருக்கிறேன் மற்றும் எந்தவித அச்சம், அச்சுறுத்தல் அல்லது தவறான கண்ணோட் க்கு ஒப்புதல் அளிக்கிறேன் என்று இதன் மூலம் நான் மேலும் உறுதிமொழியளிக்கிறேன்.
என்றும் மற்றும் என்னுடைய மேலும் இந்த படிவத்தில் நா எனது முன்னினலயிலேயே பூ இந்த மருத்துவ செயல்முறை ந்நும் சிக்கல்கள், உத்தேசி மலே பெயர் குறிப்பிடப்பட் வயதுக்கு மேற்பட்ட, சீரான இல்லாமல் இச்செயல்முறைக்	ான் கையொப்பமிடும்போது, இந்த படிவத்தில் சேர்க்க வேண்டிய அல்லது பூர்த்திசெய்ய வேண்டிய அனைத்து பகுதிகளு பூர்த்தி செய்யப்பட்டன என்றும் நான் உறுதிமோழி சுறுகிறேன். பட்ட, மேலே குறிப்பீடப்பட்டுள்ள மருத்துவ செயல்முறைகளுக்கு மேலே பெயர் குறிப்பிடப்பட்டுள்ள நோயாளியான நா றுயை மேற்கொள்வதற்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை தருகிறேன் மற்றும் இதன் தன்மை, வாய்ப்புள்ள இடர்ச சிக்கப்படும் பலன்கள் மற்றும் சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்றி நான் முமுமையாக அறிந்திருக்கிறேன். ட்டுள்ள நோயாளியான / நோயாளியின் பிரதிநிதியான நான், இப்படிவத்தில் கையொப்பமிடும் தேதியில் 18 ஆண்டுவ நல்ல மனநலம் கொண்ட நபராக இருக்கிறேன் மற்றும் எந்தவித அச்சம், அச்சுறுத்தல் அல்லது தவறான கண்ணோட் க்கு ஒப்புதல் அளிக்கிறேன் என்று இதன் மூலம் நான் மேலும் உறுதிமொழியளிக்கிறேன்.
என்றும் மற்றும் என்னுடைய மேலும் இந்த படிவத்தில் நா எனது முன்னினலயிலேயே பூ நான் அறியுமாறு விளக்கப்ப இந்த மருத்துவ செயல்முறை நற்றும் சிக்கல்கள், உத்தேசி மலே பெயர் குறிப்பிடப்பட் வயதுக்கு மேற்பட்ட, சீரான இல்லாமல் இச்செயல்முறைக் நோயாளி பதிலாள் / பாதுகாவலர் (பொருந்துமானால் #)	ான் கையொப்பமிடும்போது, இந்த படிவத்தில் சேர்க்க வேண்டிய அல்லது பூர்த்திசெய்ய வேண்டிய அனைத்து பகுதிகளு பூர்த்தி செய்யப்பட்டன என்றும் நான் உறுதிமோழி சுறுகிறேன். பட்ட, மேலே குறிப்பீடப்பட்டுள்ள மருத்துவ செயல்முறைகளுக்கு மேலே பெயர் குறிப்பீடப்பட்டுள்ள நோயாளியான நா றுபை மேற்கொள்வதற்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை தருகிறேன் மற்றும் இதன் தன்மை, வாய்ப்புள்ள இடர்ச சிக்கப்படும் பலன்கள் மற்றும் சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்றி நான் முழுமையாக அறிந்திருக்கிறேன். ட்டுள்ள நோயாளியான / நோயாளியின் பிரதிநிதியான நான், இப்படிவத்தில் கையொப்பமிடும் தேதியில் 18 ஆண்டுவ நல்ல மனநலம் கொண்ட நபராக இருக்கிறேன் மற்றும் எந்தவித அச்சம், அச்சுறுத்தல் அல்லது தவறான கண்ணோட் க்கு ஒப்புதல் அளிக்கிறேன் என்று இதன் மூலம் நான் மேலும் உறுதிமொழியளிக்கிறேன்.
என்றும் மற்றும் என்னுடைய மேலும் இந்த படிவத்தில் நா எனது முன்னிலையீலேயே பு நான் அறியுமாறு விளக்கப்ப இந்த மருத்துவ செயல்முறை றற்றும் சிக்கல்கள், உத்தேசி மேலே பெயர் குறிப்பிடப்பட் வயதுக்கு மேற்பட்ட, சீரான இல்லாமல் இச்செயல்முறைக் நோயாளி பதிலாள் / பாதுகாவலர் (பொருந்துமானால் *) பதிலாள் ஒப்புதல் வழங்குவதற்கு காரணம்	ான் கையொப்பமிடும்போது, இந்த படிவத்தில் சேர்க்க வேண்டிய அல்லது பூர்த்திசெய்ய வேண்டிய அனைத்து பகுதிகளு பூர்த்தி செய்யப்பட்டன என்றும் நான் உறுதிமோழி சுறுகிறேன். பட்ட, மேலே குறிப்பீடப்பட்டுள்ள மருத்துவ செயல்முறைகளுக்கு மேலே பெயர் குறிப்பீடப்பட்டுள்ள நோயாளியான நா றுபை மேற்கொள்வதற்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை தருகிறேன் மற்றும் இதன் தன்மை, வாய்ப்புள்ள இடர்ச சிக்கப்படும் பலன்கள் மற்றும் சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்றி நான் முழுமையாக அறிந்திருக்கிறேன். ட்டுள்ள நோயாளியான / நோயாளியின் பிரதிநிதியான நான், இப்படிவத்தில் கையொப்பமிடும் தேதியில் 18 ஆண்டுவ நல்ல மனநலம் கொண்ட நபராக இருக்கிறேன் மற்றும் எந்தவித அச்சம், அச்சுறுத்தல் அல்லது தவறான கண்ணோட் க்கு ஒப்புதல் அளிக்கிறேன் என்று இதன் மூலம் நான் மேலும் உறுதிமொழியளிக்கிறேன்.
என்றும் மற்றும் என்னுடைய மேலும் இந்த படிவத்தில் நா எனது முன்னிலையீலேயே பூ நான் அறியுமாறு விளக்கப்ப இந்த மருத்துவ செயல்முறை நற்றும் சிக்கல்கள், உத்தேசி மேலே பெயர் குறிப்பிடப்பட் வயதுக்கு மேற்பட்ட, சீரான இல்லாமல் இச்செயல்முறைக் நோயாளி பதிலாள் / பாதுகாவலர் (பொருந்துமானால் #)	ான் கையொப்பமிடும்போது, இந்த படிவத்தில் சேர்க்க வேண்டிய அல்லது பூர்த்திசெய்ய வேண்டிய அனைத்து பகுதிகளு பூர்த்தி செய்யப்பட்டன என்றும் நான் உறுதிமோழி சுறுகிறேன். பட்ட, மேலே குறிப்பீடப்பட்டுள்ள மருத்துவ செயல்முறைகளுக்கு மேலே பெயர் குறிப்பீடப்பட்டுள்ள நோயாளியான நா றுபை மேற்கொள்வதற்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை தருகிறேன் மற்றும் இதன் தன்மை, வாய்ப்புள்ள இடர்ச சிக்கப்படும் பலன்கள் மற்றும் சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்றி நான் முழுமையாக அறிந்திருக்கிறேன். ட்டுள்ள நோயாளியான / நோயாளியின் பிரதிநிதியான நான், இப்படிவத்தில் கையொப்பமிடும் தேதியில் 18 ஆண்டுவ நல்ல மனநலம் கொண்ட நபராக இருக்கிறேன் மற்றும் எந்தவித அச்சம், அச்சுறுத்தல் அல்லது தவறான கண்ணோட் க்கு ஒப்புதல் அளிக்கிறேன் என்று இதன் மூலம் நான் மேலும் உறுதிமொழியளிக்கிறேன்.



Patient Details (Affix Label here)

Name:

DOB: So



Every heart beat counts

கீழே கையொப்பமிட்டுள்ள மருத்துவராகிய நான், திட்டமிடப்பட்டுள்ள அறுவைசிகிச்சை / மருத்துவ செயல்முறையின் தன்மை, சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள், உத்தேசிக்கப்படும் பலன்கள், செயல்முறைக்குப் பிறகு எதிர்பார்க்கப்படும் போக்கு மற்றும் செயல்முறைக்கு சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்றி நோயாளியிடம் / நோயாளியின் பிரதிநிதியிடம் விளக்கியுள்ளேன். மேலும் இந்த ஆவணத்தில் விவரிக்கப்பட்டுள்ள தகவலை அவர் / அவள் முழுமையாக புரிந்துகொண்டுள்ளார் என்று நான் உறுதியாக நம்புகிறேன்.

	கையெய்பம்			பெயர்	-		பதிவு எண்,		தேதி	நேரம்
ஒப்புதலை பெற்ற நபர்										
	உடல்	சாரந்த தடுப்ப	க்காப்பு		இன்றிய	மையாத அறி	தறிகள்			
தேதி & நேரம்	வலது பக்கத்தில்	CRT <3 Sec ஆம் / இல்லை	சருமம் சிதையா நிலை	வெப்ப நிலை (f)	நாடித் துடிப்பு (விகிதம் / நிமிடம்)	சுவாசம் (விகிதம்/ நிமிடம்)	இரத்த அழுத்தம் (mm/ Hg)	SpO 2	தடுப்புக்காப்ப ிலிருந்து விடுவிப்பது 2வது மணி நேரத்தில்	கையொப்ப ம்
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குறிப்பு: ஐசியு நோயாளிகளுக்கு இன்றியமையா அம்ச அறிகுறிகள், ஐசியு ∴புளோசார்ட்டில் கண்காணிக்கப்படும் சிக்கல்கள்: 🗆 ஆம் 🗆 இல்லை (ஆம் எனில், அறிகுறிகளை குறிப்பிடுக)

	பாதிப்படைந்த சரும முழுமை நிலை	நீலம்பூரித்தல்		தோல் வெளுப்பு
	குளிர்ச்சியான மற்றும் பசை போன்ற	சிலிப்பு உணர்வு		உணர்வின்மை/மரத்துப்போதல்
l	சருமம்		<u> </u>	
	தடுப்புக்காப்பினால் காயம் அல்லது கீழே	அதிகரித்திருக்கும் குழப்பம் / பதற்றம் / சூழல்) ഉ	ணர்வின்மை
	விழுதல்			
	மற்றவைகள்			•





Mr.Anantha Krishnan.p.n

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





Date: 15 12 23

Time: 12.30

ICU PROGRESS NOTES

Doctor's Name : Dr. ANSIA.

ICU SCORES (as Appropriate) CLIF ACLF / AD score:

SOFA score:

MELD score:

AARC score:

SAPS II score:

APACHE II score:

Cardiac Output -

ICU Day

Background

Sevena AS

BPH / ? ADUMD

om (ITW

? UTI / DUINAL PAGEMONAS

Issues last 24 hours

NURMAR W- 60%

Central nervous system

Conscious / oriented / sedated with

Sedation score

GCS - E V M

Pupils

Pain score

Drains

Cardiovascular system

HR- PO Rhythm -

CVP -

BP - 14000

Cardiac Medications:

Respiratory system

Oxygen supplementation -

16 27/2

Saturation / PaO2-

MIN Corus

Ventilator: Spontaneous / Controlled Last C x R -

Drains -

OCC WIMPHAN

GIT

RISIANDE P/A

Boweis - Y / N Loose stools / Melena

Drains

NG tube: Y/N

NGA-Day

USG

CT

Nutrition & Fluids

Oral feeds / NG feeds

:TPN - formula used

Supplements

Calories / Proteins achieved:

IV fluids -

24 hour Urine output

Fluid balance

Creatinine clearance

Acidosis

Lactate

RRT - SLED / IHD / CRRT

Microbiology

Invasive lines

1.

2.

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

1 MAGNEX

2. 9 LAR

3. 7 mussen

Labs

Urea

Hb 1116

TC 4690

Platelets (

Creatinine

Na /30

Bilirubin

AST

DVT prophylaxis - Y/N

Drugs:

Mechanical - TEDS / SCD

Stress Ulcer Prophylaxis - Y/N

Drugs

Pressure sore Y / N

INR

Others

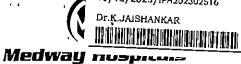
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Alpha bed Y / N

Plan for	the day			,	,,,
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Doctor	Signature	Name Dr. Anish Nelson	Reg. No.	Date /	Time
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Mr.Anantha Krishnan.p.n

79/Malc/MHI202381290 15/12/2023/IPH202302516 Dr.K.JAISHANKAR









The way to better health

(A Unit of United Alliance	e Healthcare 2-Vt Lto)	Every heart beat counts	
<u> </u>	DOCTOR'S PROGRESS NO	TES	
DATE	NOTES		
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79/Malc/MHI202381290 15/12/2023/IPH202302516 Dr.K.JAISHANKAR

Medway Hospi Manager Hospi The way to better health

DOCTOR'S PROGRESS NOTES			
DATE	NOTES		
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Mr.ANANTHA KRISHNAN.P.N

79/Male/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR

ICU PROGRESS NOTES





Date: 15/12/2023

Time: 3:40PM

INR

Others EIR - 80

Doctor's Name: Dr. Velnewyan P.

ICU SCORES CLIF ACLF / AD score: (as Appropriate) SOFA score:	MELD score: AARC score: SÁPS II score: APACHE II score:
Background - Clo Severe Aorhe Stenous cept the vere cortain Dm/HTM - Live parentymal diseas Central nervous system Conscious / oriented / sedated with Sedation score GCS - E, V, M, Pupils - 2mm M Pain score Drains -	Issues last 24 hours - If o Sois x Iday - Thrombow topensa - Elevated ESR / A process in numb - Aftered LFT / Bordense ppt / Lanin Cardiovascular system HR - 81/M - Rhythm - NUIL Cardiac Output - BP - 120/70MMBVP - Cardiac Medications:
Respiratory system Oxygen supplementation - M) Saturation / PaO2 qq, pp Ventilator: Spontaneous / Controlled Last C x R - Drains -	GIT P/A Solt Bowels - YN Loose stools / Melena Drains NG tube: Y/A Day NGA- USG - Live parentymal diseas Splenary CT postmany aly
Nutrition & Fluids Oral feeds / NG feeds TPN - formula used Supplements Calories / Proteins achieved IV fluids - 24 hour Urine output - Adequal Fluid balance - Negative holam. Creatinine clearance Acidosis _ Lactate RRT - SLED / IHD / CRRT -	Microbiology Invasive lines 1. one ! 2. Foley's Yes / No ET Tube / Tracheostomy tube - Y / ANDay Culture reports Antimicrobials with days 1. If. Myner of 17 2. The Andrew 3. The Tampin
Labs Hb // TC 4690 Platelets (L Urea & Creatinine / 78 Na / 30 K 4 69 Bilirubin 0 : U. AST 8:6 ALT. CC	DVT prophylaxis — //N Drugs: Mechanical – TEDS / SCD Stress Ulcer Prophylaxis — //N Drugs

4-6

Pressure sore Y / N

Alpha bed Y / N

Plan for	r the day	· ·			- ,
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Doctor	Signature	Name	Reg. No.	Date	Time
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Mr. ANANTHA KRISHNAN. P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.Jaishankar

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	DO	CTOR'S PROGRESS NOTES
DATE		NOTES
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Mr.ANANTHA KRISHNAN.P.N

79/Mulc/MH1202381290

15/12/2023/IPH202302516





(A Unit of United Alliance Healtho	care Pvt Ltd)			_very heart be	at counts
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Referral: Urgent (within 3 hrs.)		(within 24 hrs.)) 		
Reason for Referral :	tonen tis	1.4	Rand		
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160035





Mr.Anantha krishnan.p.n

79/Male/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





. [→ 0 . •	OGRESS NOTES
	Doctor's Name: Do Karthin	
	ICU SCORES CLIF ACLF / AD score: (as Appropriate) SOFA score:	MELD score: AARC score: SAPS II score: APACHE II score:
	Background Severe. Aorte Sbeness. ? Congarine Liver failore. ? Congarine Liver failore. ? Congarine Liver failore. ? Congarine Liver failore. ? LDM ALL - ? AOCIAD ! nepuro senal.	Issues last 24 hours Thromboughopena
	Central nervous system Conscious / oriented / sedated with Sedation score GCS - E V M Pain score Drains	Cardiovascular system HR - Rhythm - Cardiac Output - BP - CVP - Cardiac Medications:
	Respiratory system Oxygen supplementation – (3ABA) Saturation / PaO2- Ventilator: Spontaneous / Controlled Last C x R - Drains -	P/A Bowels APN Loose stools / Melena Drains NG tube: Y/N Day NGA- USG CT
	Nutrition & Fluids Oral feeds / NG feeds TPN - formula used Supplements Calories / Proteins achieved 2500. IV fluids - 24 hour Urine output Fluid balance	Invasive lines 1. 2. Foley's Yes / No ET Tube / Tracheostomy tube - Y / N Day Culture reports Antimicrobials with days
,	Creatinine clearance Acidosis Lactate RRT – SLED / IHD / CRRT	1. AZER 2. Carrogle. 3.
	Labs Hb TC Platelets Urea Creatinine Na K Bilirubin AST ALT INR Others IAC: 1.2 (5/12).	DVT prophylaxis – Y/N Drugs: Mechanical – TEDS / SCD Stress Ulcer Prophylaxis – Y/N Drugs Pressure sore Y / N Alpha bed Y / N

Plan fo	r the day			•	,
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Mr.ANANTHA KRISHNAN.P.N

79/Male/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR

ICU PROGRESS NOTES





Every heart beat counts

Date: 16/12/23

Time: IIPM

Doctor's Name: Dr. Velnungan P

ICU SCORES (as Appropriate) CLIF ACLF / AD score

SOFA score:

MELD score:

AARC score:

SAPS II score:

APACHE II score:

ICU Day - 2 Background

· Severe Aorhic Stewons

· conjertire lever failure · Dm | HTV | AKI (Hepatoser - Ford

Issues last 24 hours

- Altered seuronum

- post-Asuric tappuy

- Thromboytopenia / Febrilo emodes

Central nervous system

Conscious / oriented / sedated with

Sedation score

GCS - E N, M

Pupils - dmMEM

Pain score

Drains —

Cardiovascular system

HR - 72/M - Rhythm - NJR-Cardiac Output -

BP- 110 10 MONR

Cardiac Medications:

Respiratory system

Oxygen supplementation - 21h 02-

Saturation / PaO2- 99 %

Ventilator : Spontaneous / Controlled Last C x R -

Drains -

GIT

P/A folt

Bowels - Y/N Loose stools / Melena (on hooze enemy)

Drains -

NG tube : Y LN

Day NGA- ---

2.

USG -

CT

Nutrition & Fluids

Oral feeds / NG feeds

TPN - formula used

Supplements

Calories / Proteins achieved: Ade vat

24 hour Urine output - Nyahm halam Fluid balance | 1816 m1

Creatinine clearance

Acidosis

Lactate

RRT - SLED / IHD / CRRT

Microbiology

Invasive lines

1. one PL

Foley's Yes No

ET Tube / Tracheostomy tube - Y / N-Day

Culture reports

Antimicrobials with days

1. - Pah-Aue

2. The - Tarribu

Labs

Hb 10-7 TC 1/20-0 Platelets 8000 0

Urea 31 Creatinine (-6)

K 3-71 Na 130

Bilirubin 0-57 AST 66

1.2

Others

DVT prophylaxis - X/N

Druas:

Mechanical – TEDS / SCD

Stress Ulcer Prophylaxis -4/N

Drugs

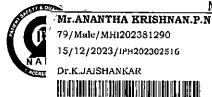
Pressure sore Y / N

Alpha bed Y / N

Doctor	N	Dr. nel		26 / 12 fr	1000
	Signature	Name	Reg. No.	Date	Time
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MHI/IP/2022/041

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DOCTOR'S PROGRESS NOTES NOTES DATE 01-00



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



Mr.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





Every heart beat counts

ICU PROGRESS NOTES

Doctor's Name :

ICU SCORES

CLIF ACLF / AD score:

(as Appropriate)

SOFA score:

MELD score:

AARC score:

SAPS II score:

APACHE II score:

ICU Day D. Background

Issues last 24 hours

Central nervous system

Conscious / oriented / sedated with

Sedation score

GCS - EuV M Pain score

Pupils

Drains

BIL PERLA

Cardiovascular system

~Rhythm - W 1 Cardiac Output -

CVP -

Cardiac Medications: 5,52

Respiratory system

Oxygen supplementation -

Saturation / PaO2- 94 / _ c Ventilator : Spontaneous / Controlled

Last C x R -

Drains -

GIT

P/A

Bowels - Y/N Loose stools / Melena

Drains

NG tube: Y/N~

Day NGA-

USG CT

Nutrition & Fluids

Oral feeds / NG feeds

TPN - formula used

Supplements

Calories / Proteins achieved:

IV fluids -

24 hour Urine output

Fluid balance

Creatinine clearance

RRT - SLED / IHD / CRRT

Acidosis

Lactate

Microbiology

Invasive lines

1. purio

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

Labs

Hb

TC

Platelets

Urea

Creatinine

Na

Bilirubin

AST

ALT

INR

Others

DVT prophylaxis - 47/N

Drugs:

Mechanical - TEDS / SCD

Stress Ulcer Prophylaxis - Y/N

Drugs

Pressure sore Y / Nc

Alpha bed Y / N

Plan for the day				,	, 3
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Mr.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





Date: 1412/13

Doctor's Name: Dr. Velnunyau P.

ICU SCORES (as Appropriate) CLIF ACLF / AD score:

SOFA score:

MELD score:

ICU PROGRESS NOTES

AARC score:

SAPS II score:

APACHE II score:

ICU Day - 3 Background

- Severe Azone Stevens

Issues last 24 hours

- poet sanhi trong

- Thromboutopun

Central nervous system

Conscious / oriented / sedated with

Sedation score

GCS - E, Y_M6

Pupils - 2 mm

Pain score

Drains

Cardiovascular system

HR - 74 / Rhythm - No L Cardiac Output -

BP-11010 CVP-Cardiac Medications:

Respiratory system

Oxygen supplementation – 2(L 4)

Saturation / PaO2- 94

Ventilator : Spontaneous// Controlled

Last C x R -Drains -

GIT

ROTT P/A

Bowels - Y/N Loose stools / Melena

ET Tube #Tracheostomy tube - Y / N.Day

Drains

NG tube: Y/N/

Microbiology

Invasive lines

1. mu h

Culture reports

Foley's Yes / No

NGA-Day

2.

Mechanical - TEDS / SCD

USG

CT

Nutrition & Fluids

Oral feeds / NG feeds

TPN - formula used

Antimicrobials with days

Supplements
Calories / Proteins achieved: Adequable
IV fluids 24 hour Urine output
Nyah halan 1.

Creatinine clearance

Acidosis

Lactate

RRT - SLED / IHD / CRRT

2.

3.

Labs

Hb

Platelets

Urea

Creatinine

Na

K

Bilirubin

AST

ALT

Stress Ulcer Prophylaxis --X/N

DVT prophylaxis - Y/N

Drugs:

Pressure sore Y/N

Alpha bed Y / N-

INR

Others

Plan fo	r the day			i	
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MI.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516





ICU PROGRESS NOTES

Date: De AMESH ICUPR Time: 8.00 Doctor's Name: De - ANISSIA	OGRESS NOTES
ICU SCORES CLIF ACLF / AD score: (as Appropriate) SOFA score:	MELD score: AARC score: SAPS II score: APACHE II score:
ICU Day 4- Background SENEME AS CONGRENIE VINED FOR LUNG DM/ 150 AR/ 1:452 ASDING SONO ROMA SONO ROMA CONGRENIE	Issues last 24 hours I wow pure min / 1 cu ps u cusses I'll, marina Ac weverum Tippem Bo co so Pomins
Central nervous system Conscious / oriented / sedated with Sedation score GCS - E, V, M, Pupils Pain score Drains	Cardiovascular system HR - 子 Rhythm らん Cardiac Output - BP - ロット CVP - シャー Cardiac Medications:
Respiratory system Oxygen supplementation - 24 9 3 Saturation / PaO2- 4-94 2- Ventilator: Spontaneous / Controlled Last C x R - Drains -	GIT P/A J. Ft Bowels - Y/ N Loose stools / Melena Drains NG tube: Y / N Day NGA- USG CT
Nutrition & Fluids Oral feeds / NG feeds TPN – formula used Supplements Calories / Proteins achieved: IV fluids - 24 hour Urine output Fluid balance Creatinine clearance Acidosis Lactate RRT – SLED / IHD / CRRT	Microbiology Invasive lines 1. 2. Foley's Yes / No ET Tube / Tracheostomy tube - Y / N Day Culture reports Antimicrobials with days 1. かいいがた 2. ににたない
Labs Hb 10-4 TC 9820 J Platelets 900000 Urea 666 Creatinine 2.0 ff Na K Billirubin 1.2 AST 74 ALT 27 INR Others	DVT prophylaxis - Y/N Drugs: Mechanical - TEDS / SCD Stress Ulcer Prophylaxis - Y/N Drugs Pressure sore Y / M' Alpha bed Y / N'

Plan for	the day	AND HBE- NR HEN - NORUMNING	- 1	- ว	
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	Signature	Name	Reg. No.	Date	Time
Doctor	Anley	Dr. Anish Nelson	Dr. Anish Nelson	18/12/23	8,60







15/12/2023/IPH202302516

Dr.K.JAISHANKAR

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	DOCTOR'S PROGRESS NOTES
DATE	NOTES
18/12/23	S/B Dr. Jaichantas Xteam.
gam	
	- Pt reviewed
	E= Comeran, oriented.
	PR-62/m, BP-135/64(88)
	T 1980 902 97% on 2102
	0 /1250. CM=840 ESMO
	PL'BAE D
	TC-0800- BJ. Bouch crpt (7)
	TC-9800- Hb-10.4 Hr-90,000 — Cont the Same
	Hr- 90,000 - Cour the same
	- I By: Dylor 20-10-0.
	_ Shift to room today,
· · · · · · · · · · · · · · · · · · ·	- Greitro reviews Dr-Kantlik- my
	(MG). 0124
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DATE	NOTES
18:12:23_	SB Do Anusuya
11. EDDLO	Patient reviewed.
	do' Chestpain on 8 066
	DIE POHENT CONSCIOUS
vitals stable	SIE! US-6162P)
May Son	
	pdvice.
	- monitos vitals
	- confinue the daugs as per
12 M	schart.
(1341)	- W/F Fluerspikas/ doraturation/
	- Glastop review
	 -
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	<u> </u>
	<u> </u>







Mr.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.Jaishankar

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	DOCTOR'S PROGRESS NOTES
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DATE	NOTES
19/12/23	SB: Dr. Tais Langar. Hearn.
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	No fevor. No Cet pi No Sto
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	Drosiented to Place Gebrale
	true.
* • • •	No flapping tremor
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	Byp. 10412 NS. 6 LIDE.
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	- Stool orcult phood
	The few bono
	C35 PFT Pypels

DATE	NOTES
19.12-23.	SIB Do. S. Sonder DMO.
4:20 Pm	
-	pt reviewed ole pt consciors osi enter
	ole pt consciors
	osi enter
	afebrik.
	CVS-5152 @
	RS - BAS C
	Adv
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	- monstor vitalo - follow drug chast - W/F feres spike,
	- W/F feres spike,
	Desaturation
	153 200
1 101	SIB Dr. Mbhamed Hydroos
19/12/23	Α. Δ. π. Δ. 1.5. (2)
	& D'. Severe Aortre Blenson)
	Congestive lover failure [72Dm]
	HTN/AKI
	? Herah renal Syndrome
	2. Hepato encephalography
<u> </u>	What Patrent disordented to Place
	Patront disorbated to Place
.	Afebrile Person.
	i jeme
	CNS->S(SZP)
	rs-, MED AW
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MHI/IP/2022/041

79/Malc/MHI202381290 15/12/2023/IPH202302516

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Dr.K.JAISHANKAR

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	DOCTOR'S PROGRESS NOTES
DATE	NOTES
	1925 Takhandean & Jeanns
ev/P	bt served
	- Of general, ordered
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	Sper 96% RA
	an= 940
	Pe-BACO Adu
	- MGE revery,
, ,	To do _ Remove and Certhety
	CBC - Plan d'e today after MAE
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	long.
^	anen
80/12/23	5/B DT-ADUSLUICI
	= A COUSE OF FOURTH AS CHE TOOM HTM ALOT
-40PM	patient reviewed perponding to hepatic encep
	0/5' dxowsy, applying painty stimuli
2-67.6/M	3/5' CNS - 5/62 P)
- NO TOM	
2-20 mir) /)
1-195mg	HI - INHOOM DO Flaishanka
1 - 195 MJ	

DATE 20/12/22	B Do Jaishankan (Cardus)
3.20PM	Patient deviewed.
	O/8' drowsy .
	- Stop discharge process - Start TUF 3000 hx
481 1	atter shirting to Icu. - DO ABOT.
134559	Medical agetto società.
20 12 23	bordons by Do Kritiga mam (Icu)
H-00 Pm	- TO do ABOI & electrolytes
701	now (immodiately) - W/F desaturation Fever
THE COUNTY	SPI KUS









Every heart beat counts

	DOCTOR'S PROGRESS NOTES	
DATE	NOTES	
	81B Dr. Marthy	
110/23		
30/10/33	pt drowsy	
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	erovsalle. Confined.	
	as: sur no aohur	
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	Ble wheer & RKL	•
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1 285	76 7450 A16: 3.5 plb 1,51,000 CB 6,27 182	
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1 pil	Cret: 1.83. K: 3-69.	
	ABL J. 7.507/36/65/28.5/	
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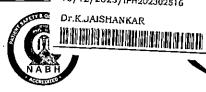
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P/2022/041









Every heart beat counts

	DOCTOR'S PROGRESS NOTES
DATE	NOTES
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20,00	
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	Obeys Commande.
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	Rp-802-854. Congestivelive facture (102-944 DM/HIN/P.
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	Ahr. → In; Dy TOR 20-0-10-0. Jv.
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	- Lacki hap- 15ml bol.
	- Send neine RUE
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DATE	NOTES
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22/17/2023	S/B DV. KIRZHIHA.N
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-	Care reviewed.
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	(20) 3 (1)
-	COP- good.
RPC	HD Sable. Sencai-good.
	RD sable. Sencai-good.
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	(3) Can Carridge Carred al-14.
	1) V.K. DZKIKA.N
,	DVK, DZRIKA.N 8765P

<u>_</u>



Mr.Anantha Krishnan.p.n

THE REPORT OF THE PROPERTY OF

	DOCTOR'S PROGRESS N
DATE	NOTES
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10.0	patient reviewed.
	Clo,
	0/5: patient conscious, onerled:
1000 JOHNOS	
The Color	0 SB. CMS-6162 D
JON WAY	RS - BAE (P)
DA 10	vitals: HR-846/M
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	0010110000 (1-
	Perchast - mars opinuon - chest physio, mobilisato
Marin .	
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DATE	NOTES	
23.12.23	course in the hospital	
H-DO AM		
110	Ataylm came with 410 short ness or	
	breath on groth for 110 clarks. HIN BITTERS	
	swelling + + + + 16 Loss of appointe (1). A lo generalized	
	throadness Patient got admitted under Dr. Haisnanyax	
TO	cardio baseline investigation (cardio)	
	unroused total count, increased creatining Louel.	
ny phonal smax	usu abdomen showed splenomegaly, prostato magaly	
sample sent	minimal B/L Pleural effusion, moderate excite, Liver	•
	Parenchymaldhease: Echodone EF-607	
	Due to O Abdominal Run & Splenomegaly, Dr. Kanthik	
	complical faction) opinion opposing of he admiced for	
	oper scopy stool occult blood should negative	
	Ascitte tapping done of samples sent to cultipage.	
	TROTTE TIME analysis, patriots an fallon symptomatically	
	CODING STUFFLED TO WOUND THE 18.12.23 WITH	
	CBDUNKHUP) ? Due to complaint of black coloured	
	stools, stool occut blood sample sent showed negative upided forcely a consomound. Due to doowley, disonented	(
	to place, time, breathlessness patients shiften to I cu on	r
	20.12.22. ABUT dane. Due to source Blc exepts	
	nobulisation stanted. Then, Potient improved symptomatica	lli.
	& hence being shifted toward on 28.12.23. Do-Jaisha	nka s
	Cardio soviewed the project periodically of adured	, oracol
1	Followed. portient was tocated with In Fluids anti-biother	
(B)	analyeria, anti-punctice of other suppostive measures	ر
A MILE	patient im proud symptomatically a deeling better a hence	
	being discharged with Advice modelcotton	
	<u> </u>	









Every heart beat counts **DOCTOR'S PROGRESS NOTES NOTES** DATE 05





MIT.ANANTHA KRISHNAN.P.N

79/Male/MHi202381290 15/12/2023/iPH202302516

Dr.K.JAISHANKAR



CONSENT FORM - PHYSIOTHERAPY

I, ANCIMMENT Read Read We have been explained the current clinical condition of me/my patient Read (Name of language) which I fully understand and understood the information provided about Operation / procedure
(full name of operation / procedure given below in this consent form)
Brief description of the Operation/Procedure: AROM Fx's, Moblishon, Chest permison.
I understand the intended benefits of undergoing the procedure. The intended benefits from this procedure are: To Improve Mulle Shunghle, To Improve Lung Language To Improve ADL I understand that all procedures carry certain risks. The potential risks and complications from this procedure:
N;17
I have been explained the implications of not undergoing this procedure and the alternative methods of treatment like:
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 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 signing this form.

Signature of Patient / Patient's Relative (only if Patient is unable to sign);						
Dr. Svay	nentioned operation(s) / procedure (name of doc myself or my above named in the contract of th	ctor performin	g the operation / prod	cedure) for carrying	out the said ope	ration / ations,
	ned Patient / named patient's repre his form, mentally sound and am g					on the
	Signature / Thumb Impress	sion*	Name		Date	Time
Patient						
Surrogate/Guardia (if applicable #)	an	(Wri	ite name and relation	ship with patient)		
Reason for surrogate consent	Patient is unable to give co	onsent becau	ise:		·	
Witness				`.•		
Interpreter (if applicable)		. –				
I, the undersign	es & Left Hand for Females # Only ned doctor, have explained the names, and possible alternatives to the e/she has understood the informa	ature, potent ne planned op	eration / procedure,	cations, intended be to the patient / patie		
	Signature	Name		Reg. No.	Date	Time
Consent obtained by	duf-k	ζ.	7 P	John	22/11/23	113:00
Procedure performed by	8-1.R	D /	Buryar	2em	22/12/13	11:30a
		/				1

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Medway Hospitals® The way to better health

Mr.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR



PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
22/12/23	11:300	m C/B Sunga:R	
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		BPH	
		FLLN. DW.	
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		& chart permison 20	
		B/c chert wall	
		P/L Cher	





Mr.Anantha krishnan.p.n

79/Mulc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR

URINE ROUTINE ANALYSIS MICROBIOLOGY SHEET

DATE	14 12 23			
COLOUR	PALEYELOW			
REACTION				
SPECIFIC GRAVITY				
APPEARANCE	SLIGHTLYTURED			
ALBUMIN				
SUGAR	NIL.			
ACETONE			 	
BILE SALT				
BILE PIGMENT				ì
UROBILINOGEN				
PUS CELLS	4-6			
EPITHELIAL CELLS	6-8			
RBC	NIL			•
CASTS	NIL			
CRYSTALS	NL		 	
OTHERS	BACTERIA PRESENT.			
		<u> </u>		

MICROBIOLOGY-CULTURE REPORTS

DATE	SPECIMEN/SITE	GROWTH- 24h, 48h, ORGANISM	SENSITIVITY
15)12/2	Urine C/S	No growth	



1)





Every heart beat counts

Mr.ANANTHA KRISHNAN.P.N

79/Malc/MHi202381290 15/12/2023/JPH202302516

Dr.K.JAISHANKAR



DIABETIC CHART

ACTUAL WEIGHT = 60. HbA,c 7.6 [14]12]23] PREVIOUS DIABETIC MEDICATIONS .. DIABETIC DRUG TIME **ENDORSED BY** DATE **BLOOD SUGAR** Sign. 12.30 (DR. ANISU 2010 13.40 18.50 8.00

*	Mix 40u short acting Insulin in 40 ml. of normal Saline (IU - 1 ml.)	mg / dl	INSULIN INFUSION
•	Start Insulin Infusion 1-2 u / hr	< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
*	Monitor Blood Glucose hourly (every 2nd	150-200	Adjust Infusion rate to 2u / hr.
	hourly when stable) and adjust Insulin rate according to the following Algorithm.	201-250	Adjust Infusion rate to 4u / hr.
		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.





DIÁBETIC CHART



Every heart beat counts

Mr.ANANTHA KRISHNAN.P.N

79/Male/MHI202381290 15/12/2023/iPH202302516

Dr.K.JAISHANKAR

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<i>(</i>	٨	 1

ACTUAL WEIGHT TO NO. Kg. HDA,C. F. D. 19/12/23

PREVIOUS DIABETIC MEDICATIONS PARS. PEREQUIP M 20/50 Mg. 1-0-0

DATE TIME BLOOD SUGAR DIABETIC DRUG Sign. ENDORSED BY

1-1/2/23 12.00 197 mg/dl Thy. HA HU 9/28/22/25/14/10/24/14/19

18.30 141 mg/dl Thy. HA SU 9/2 Sht 9/10 Dr. Karthick.

20/12/23 15.30 200 mg/dl Thy. HA SU 9/2 Sht 9/10 Dr. Karthick.

12.60 191 mg/oll in 4.0-40xits. W. H 22. Salai six

INSTRUCTIONS FOR INSULIN INFUSIONS

	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.
*	Manitor 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.



DIABETIC CHART

MH/DC/IP/2023/038

PATIENT DETAILS: 15/12/2023/IPH202302516

79/Malc/MHJ202381290

ACTUAL WEIGHT

Dr.K.JAISHANKAR
DAN 1814 EMELDIYA (184 DOKA HUBAD (1714 MIDI MIDIA HOKA LOKU DOL

___ SERUM CREATININE CLEARENCE _____

TSH _____

PREVIOUS DIABETIC MEDICATIONS

DATE	TIME	BLOOD SUGAR VALUE	DIABETIC DRUGS	DOCTOR SIGNATURE	STAFF SIGNATURE	CHARGE NURSE SIGNATURE
12/23	ЬЗОРТ	IBINUIA		DEKARTHE.	1/201	LOS LOS LOS
2/12/23	l30Am	148HU/N	`	DR. HIR-141K	1133	000
	<u> 10.20Pm</u>	श्रेष म्बर	<u> </u>	ioe-kirthika	2500	000 004 100 124
	<u>k.30 pm</u>	160 mg ld		Dr. Hopish	D ₁	10e
reluler	(1,30 84)	192MU/10	. :-	De HARISH	4 5 TO 1741	131
ļ	1730 Sec.	302 mg ld	HA- Devil	DR. KIRTHIKA	frol .	100
	P.842	180 mg lol		KAN	火, ~~	NOC
0.3/12/23	6-30	203M/	le Inj. HTA-6J	Ordina.	3960214	122
	12-30	191 mgldz				
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				• ',		





Mr.ANANTHA KRISHNAN.P.N

79/Male/MHi202381290 15/12/2023/iPH202302516

Dr.K.JAISHANKAR

BLOOD GROUP

O POSITIVE.

INVESTIGATION SHEET

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Date	14/12/23	15/12/23	16/10/28	17/12/23	18/12/23	2011212	1
HAEMATOLOGY				, , , , , , , , , , , , , , , , , , , 		./	
Hb	11.6		10.7		10.4	11.9	
P.C.V	34.0		2-8.14			368	
Platelets	100000	75,000	800001	85 OOD	90000	151000	
TLC	4-690		4,500	13950		7450	
Polymorphs	1		63.8		78.4	69.1	
Lymphocytes	64.1 19.4		29.6		15.8	18.4	1
Eosinophils	5.6		1.7	-	10),	4.6	
Mono / Basophils	10.5/0.4.		4.9/00		4.7 0.0	7.5 00	1.
E.S.R	80						
BIO-CHEMISTRY							ļ
Urea	28	33	31_		56	37	
Creatinine	<u>4.78</u>	4.63	1.61		2.07	1.83	
Sodium	1.30		130	\	135	136	136
Potassium	4.09		_२.म।		3.62	3.60	368
Bicarbonate	'P		20		25	22	21
Chloride	95.4		9 ଥ	· -	93. 5	92.1	&ବ
Magnesium						1	
Calcium	8.6		8.8	_	8.6	9.6	
Phosphorus	3.4		3.0	-1 -1 - 0	4.1	3.0	
LFT USICARIO	·			12/23		,	
T.Bilirubin	0.95		0.87	1.20	_	0.90	
D,Bilirubin			0.39	0.65		0-24,	
I.Bilirubin	0.44			0.55		0:74	
S.G.O.T	88		के भेष्ठ	74		62 15	
Ś.G.P.T	<u> </u>			27		15]
ALP	134		123	80		<i>&</i>)	
GGT	134 65 8.4		6-8	52 8·1		46	
Total Protien	8.4		8·1			9-0]
S.Albumin_	3.2.		3.1	3.4		912	
CARDIAC ENZYMES				·			
Troponin I							
CKNAC - CPK							
CK - M.B. MASS							[
LDH					۶.]
Ntpro bnp		10Q.					

Date	14 12 23.	15/12/23.			<u>i</u>	1 1 /
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		امروا			<i>i</i>	
		1.2		_		
D Dimer Control		15·A				'
LIPID PROFILE		12.1				
Total Cholesterol	95		-			
	<u> </u>					
Triglyceride H.D.L						
L,D.L	27					
	49					
V.L.D.V						·
THYROID FUNCTION				9 46		
T.S:H				<u> </u>		
T.3						
T.4						
SEROLORY			-			
HIV		•	` ,			
HBsAg						
V.D.R.L				<u> </u>	<u> </u>	
COVID 19				<u> </u>		
RT- PCR						
lgM ·						
Ìg				·		
HBA1C					<u> </u>	
FBS/PPBS				·		
RBS						
S.AMYLASE			· ;	·	·	
S.LIPASE		·	_		_	
C.R.P		· .		<u> </u>		
PROCALCITONIN		<u> </u>		<u> </u>		
DDIMER				<u> </u>		
S.Osmolality						
URINE		<u> </u>				
Osmolality						
Spot - Na		1.				
Motion occut Blo	al	Negative				
Motion occut Blo Sq. ALBUMN. Gold	23 22			<u> </u>		
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The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR

110 MIN 681 MIN 70 MIN 681 MIN MIN 68 MIN

BLOOD GROUP

OHVE	

INVESTIGATION SHEET

Patient Details (Affix Label here)
Name:
UHID:

Sex:

DOB:

Date **HAEMATOLOGY** 12.8 12.1 Hb 10,4 P.C.V 36<u>8</u> **Platelets** 90000 151000 7180 TLC Polymorphs 78.5 Lymphocytes 15.8 **Eosinophils** Mono / Basophils 7.5/0.4 E.S.R **BIO-CHEMISTRY** 84 Urea 87 1.59 Creatinine 1.45 1.83 Sodium 137 136 126 Potassium 3.6 3,65 2.63 Bicarbonate ್ವಾ 21 Chloride ଟ୍ରବ 12 · Magnesium Calcium 8.6 9.6 **Phosphorus** LFT T.Bilirubin 0.98 D.Bilirubin 0.24 I.Bilirubin 0.74 S.G.O.T 62 S.G.P.T 12 ALP 31 GGT 46 Total Protien 9.0 S.Albumin CARDIAC ENZYMES Troponin I CKNAC - CPK CK - M.B. MASS LDH Ntpro bnp

						v.	1
Date						-7	}
COAGULATION						 	1
PT/INR							1
Fibrinogen						-	1
D Dimer						-	1
LIPID PROFILE					 		1
Total Cholesterol			-				1
Triglyceride							1
H.D.L.	_						ĺ
L.D.L			<u> </u>			,	1
VLDV					_	,	1
THYROID FUNCTION			,				1
T.S.H			•	•			ļ
T.3							1
T.4			- -				1
SEROLORY						-	1
HIV	_	-					1
HBsAg			7	_			1
V.D.R.L							J
COVID 19							ſ
RT- PCR	_						1
IgM	_						1
lg	i						
HBA1C					 		1
FBS/PPBS	_						1
RBS	_						1
S.AMYLASE					 		1
S.LIPASE							1
C.R.P					 -		1
PROCALCITONIN			-	-			1
DDIMER	_						1
S.Osmolality							1
URINE							
Osmolality							1
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Mr.Anantha krishnan.p.n

79/Male/MHI202381290

15/12/2023/PH202302516

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Medway Hospitals® HTN/T29M.

The way to better health

(Alloit of United Allins 1997)

(A Unit of United Alliance Healthcare Pvt Ltd)

MI.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR

110 YM 1001 YM 0010 1141 YM 1000 HOBY YP 11 DEN YD A BAULDY



VITAL INFORMATION SHEET

Diagnosis: 120m / HTM / SEVERE CALCIFIC ADRIC Procedure:

BLOOD GROUP ON ADMISSION Weight in Height in CM 7 1P8 1 60.

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MT.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516







Every heart beat counts

EARLY WARNING SCORE MONITORING CHART

NEWS key	DATE	1811	2/15	dir	19/1	10/0	19 12	AIR	1914	2011	In	2017	-20114	DATE
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	TIME	10	12,	732	60	10,00	4-60	18.00	20	6.	10.00		(2	TIME >25
tespirations	>25 21-24			-				2						21-24
reath/ min	18-20	-	-		-	*	-	- 8	-	-	-		-	18-20
	15-17													15-17
	12-14													12-14
	9-11							1						9-11
	<8		2000					3					2000	<8
A+B	>96	-	-	-			7	1			-		_	>96 94-95
SPo2 Scale 1 Oxygen Saturation (%)	94-95 92-93							2						92-93
Oxygen Saturation (20)	<91		Contract of	200	100000	-	-	3		100 mm	Real Property		CHARLES CO.	<91
Spo2 scale 2 oxygen saturation (%) use scale 2 if target range is 88-92 %	>96 on oxygen							3						>96 on oxygen
eg: in hypercapnic														
respiratory failure only	95-96 on o2							2					Marie Marie	95-96 on o2
ale 2 under the	93-94 on O2							1						93-94 on O2
on of qualified	>93 on air													>93 on air
a ""	88-92													88-92
	86-87			1				1						86-87
	84-85							2						84-85
	<83%							3						<83%
Air or Oxygen ?	A= Air	-		0	1	~	0	0	-	-07	-	-	-	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								-	- 0			-	141-160
	121-140		- 4	*		1	-		/-			VB		121-140 111-120
	91-100				49			1						91-100
	81-90							2						81-90
	71-80			STREET, STREET	ST 1283	CHICAGO I		3				-		71-80
	61-70	The state of		To Water			No. of London	3	DER TOTAL			NEW DAY		61-70
	51-60				BE !			3						51-60
	<50		1					3 70	0			- 00		<50
Diastolic BP	mmHg	62	800	70	66	30	78	82	80	86	22	29	70	mmHg
	>131						2000	3						>131
e	121-130							2						121-130
ts / min	111-120							2						111-120 101-110
	91-100							1						91-100
	81-90			-	-	*		10	-	- a	-	-	-	81-90
	71-80						-		,					71-80
	61-70													61-70
	51-60													51-60
	41-50							1						41-50
	31-40				BY 1943	DE WES	100	3					10 CO 10 CO	31-40
	<30			10000	-	STATE OF	-	3		C.				<30
D	Alert	- 1	-	0	-	4	-	10	- 6			76		Alert
Consciousness Score for New onset of	Confusion							3				9	Control of the second	Confusion
confusion	V		200	375			Ber and the same	3					PERSONAL PROPERTY.	P
(no score if chronic)	U	10000	20000	PA PATO		10000	1	3					202.00	U
E	>39.1 degree Celsius				1		1	2			F 188			>39.1 degree Celsius
Temperature	38.1-39.0							1			-			38.1-39.0
Degree Celsius	37.1-38.0		-61											37.1-38.0
	36.1-37.0			V	-40	19	-	R	_		-	9_	~	36.1-37.0
	35.1-36.0							1						35.1-36.0
	< 35.0		0		The said		No. of Concession,	3		7		Carlo See	1.	< 35.0
NEWS Total		0	· M	0	0,	0	D	0	0	0	0	4	H	
Monitoring Frequency		other	UI.	Her	Lloh	Ath	un	Q IT	14	hos	499	2	2	
Escalation of Care Y/N		180	(0)	Du	W.	100	17	74	N	N	~	2	8	
Initials by RN		N/	-	MAX	800	DC	-	10	July 1	fu	_	NA	138	
Initials by Sr. RN				A 300				4 0						

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



From: 10

Date



Bed No: 1//

To: 19/12/20

Mr.Anantha Krishnan.p.n

79/Malc/MHI202381290

15/12/2023/IPH202302516

Dr.K.JAISHANKAR

CHART

P/2022/066

Every heart beat counts

INTAKE & OUTPUT

24 Hrs: Started Time! 4-4 Ended Time: Anm NPO Over at: NPO Started at : Restricted Fluid (RF) Night SHIFT Morning Afternoon INTAKE **OUTPUT** Loson Difference: -860ml Total Intake: 1190ml **Total Output:** INTAKE (ml) **OUTPUT (ml)** Intravenous Infusion Tube N/G Drain **Endorsed** Total Time | Oral Urine **Vomitus** Others Total R/N Sign Time Feeding Type of Fluid Aspirate Tube by Additions | Amount 0140 OURDUP & MAL TOHA-P 220 280 INCA-RE M 12.30 100 M 330 18.00 480 600ml 14.00 150 N 880nf 505 1250 1700 75m 7.00 2050 Som 665 8.30 100n 790 BACT DOD 2100 940 090 150 6.00 100 1190 Roon



From: 15

24 Hrs: Started Time: 7-00

Date



Bed No:

Ended Time: I am

To: 2

1.1/23





Mr.Anantha Krishnan.p.n

79/Male/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR

INTAKE & OUTPUT CHART

NPO Started at : NPO Over at : CHART

SHIFT Morning Afternoon Night Restricted Fluid (RF)

INTAKE SOOM

OUTPUT SOOM

500 ML

Total Intake: **Total Output:** Difference: **INTAKE** (ml) **OUTPUT (ml)** Intravenous Infusion Tube Total' N/G Drain Endorsed Time Oral TOE **Vomitus Time** Urine **Others** R/N Sign Feeding Type of Fluid **Additions** Aspirate Tube **Amount** bν 1.20 A. Do 100 200 100 <u>മ</u>ക്ക 8.00 20 200 1.00 100 Sar 200 200 14:00 300 M 9.00 ጀን 9.20 O. 300 18.00 1500W 1100 03 B.30 500 1600 11-60 20 100 150 cto 250 700 18.18 Intake 100 too 1000ml total 10-60 100 1000 M 1600 \$ 50 2000 Balance bolo me Nea



From: 20

Date



Bed No: 111

To: 21/12/23





Every heart beat counts

Mr.Anantha Krishnan.p.n 79/Malc/MHI202381290

15/12/2023/IPH202302516

Dr.K.JAISHANKAR

INTAKE & OUTPUT CHART

24 Hrs: Started Time: **Ended Time:** Lam 110 MA 6001 MA 8001 MA 6001 MA 6001 MA 600 MA 600 MA 600 MA 600 MA 600 MA 600 MA 600 MA 600 MA 600 MA 600 MA 600 MA NPO Started at: NPO Over at : 7 00 Restricted Fluid (RF) **SHIFT** Morning Afternoon **Night** youn. INTAKE 500 M **OUTPUT** Total Intake: **Total Output:** Difference: **INTAKE** (ml) **OUTPUT (ml)** Intravenous Infusion **Tube** Total N/G Drain **Endorsed** Time Oral िहि Feeding Type of Fluid Time Urine **Vomitus Others** R/N Sign Aspirate Tube **Additions** Amount by 120 300 .45 150 300 16,00 100 ०० 200 esso 10,10 င္င 3 00 320 0000 50 004

	_
N MI	
1	

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_						
1	II.A	NAN	THA	KRI	SHI	AN

_) CHART

: _ 79/Mulc/MHI202381290 15/12/2023/(PH202302516

Name : - Dr.K.JAISHANKAR

Operation Performed:

Date

110 MW 1811 IN BELLEVILLE LINE 1911 IN 1811 IN 1811 IN 1811 IN 1811 IN 1811 IN 1811 IN 1811 IN 1811 IN 1811 IN

IP No. : __

Date :

MH/ PRINT / 0061 / NRS

	TEMP	RESP	PUL'	BP	SP02	IV FLUID 1	ORAL	TOTAL	URINE	NGT	DRAÍN	OTHER		DRUGS & MEDICATION	IS	
9.00 a.m.						·			-				TIME	DRUG	DOSE	RTE.
10.00 a.m.							-									
11.00 a.m.																
12.00 Noon																
1.00 p.m.							. .				=		•,			
2.00 p.m.							-	•	:	,	•					
3.00 p.m.										. '						
4.00 p.m.													:	١ ,		
5.00 p.m.											,			4 1		
6.00 p.m.						1× 400		H OU	50au			50°N	۔ اِ			
7.00 p.m.	as =	âf	弘	13/00	au1.	3 0	H20 50	1460							<u> </u>	
8.00 p.m.	98-6	to.	#0	120/10	924.	3 U	_	510				,		•		
9.00 p.m.	9250	22	b8	136/70	96%	3C		540								
10.00 p.m.	122-6	. Jr.	bb	(20/10	4181.	30		520								
11.00 p.m.	વક્રક	H	F16	120/40	('	30		600								
12.00 MN	C43-2	20	8 طر	120/20	_	30		630	DIAPPER	HAN CHEA)	FOGU	į	-		
1.00 a.m.	Q49 . J	22	ιo	130/bo		30		660		·						
2.00 a.m.	93.6	TL.	#0	120/50		30		PdD								
3.00 a.m.	90-B	16	68	150/100	927	30		72°								
4.00 a.m.	98-62	21	15	120/40	95/	80		750								
5.00 a.m.	98-0	20	by.	130/10		30.	V- 6	720	TEN.	DEAVE		HOCHC				
6.00 a.m.	96-2	(A	6-8	1 / 2	92%	30	1/20	910				7,500		e.	· ·	
7.00 a.m.	OB-6		ヺ ン	120/70		30		240								
8.00 a.m.																
SUB TOTAL																
						24 HOURS	INTAKE = C	14 out		0l	JTPUT =	1,4000	iv T			

V	

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I	•	<u> </u>	<u>KI</u>	3.1	· MH/ PRIM / UUD I / NR
Date :		_		IP No. :	
Name : :				· Age .:	Şex :
Operation Performed ::					20/12/23

	TEMP	RESP	PUL	ВР	SP02	IV FLUID:1	ORAL	TOTAL	URINE	NGT	DRAIN .	OTHER	,	DRUGS & MEDICATION	S	
9.00 a.m.	98.64	20	70	20 170	961	750		50			•		TIME	DRUG	DOSE	RTE.
10.00 a.m.	98-6/p	22	f8	190 180	971	, 30	७०	(60				: *	24	-HOS TO CHART!		
11.00 a.m.	98-6F	20	74	120 180	951	8	50	240				ì	ı			
12.00 Noon	98-20	22	72	130/70	964	40	;	N ≠•0•			* :	,	ZΝ	TAKE!		•
1.00 p.m.	980	2	74	120 20	964	60	Hos	300			1.0	2001				
2.00 p.m.	944	2	te	13, 10	95.1	`3 ₀	\$3	180	Bed	alex ((JM		J	VF- 34NML	•	•
3.00 p.m.	08-6	1	60	120hr	981	80		410						, -Se		
4.00 p.m.	98-4	B	૧૫	13vlz-	98.1	30	Tea	ho					M	ED-		
5.00 p.m.	986	æ)	78	12012	عهراء	Stop	60	490					•			
6.00 p.m.	વ્હપ	10	72	13,10	9411,								\mathcal{O}	PAL - 530HC		
7.00 p.m.	23.6	الم	20	roli	981.								•			
8.00 p.m.	G8-6	18	72	120/20	964.	420	ALP.	390						OTAL INTAKE!	9401	<u>C</u>
9.00 p.m.	98-3	10	76	120/60	98%		100		٠	,			-			
10.00 p.m.	Q&\6	12	#	136/70			Jen orth	690					0	79V71		
11.00 p.m.	વહર્સ	طا	76	130/60	96%		<u> </u>		400			700	_			
12.00 MN	06.6	18	72	120/50	as).							Mi	ر	RINE - ULBOML		
1.00 a.m.	0486	16	74	130/10	affi											
	98-8	18	72	120/40					-				٨	107/DAY NOT PASSE	2	
	96-6	F8>	to	130/00	art.				-							
4.00 a.m.	98-E] b	72	120/00					BELCE	IDE		tyco	-7.	OTHE OUTPUT! 4	y oom	٠
5.00 a.m.	982	18	72	120/50	957											
6.00 a.m.	926	10	26	140/80												·
7.00 a.m.	93-3	20	72	120/1				<u> </u>	DIAPPE	rebaige	d -	-20	^	DINDTINE BARA-	4,604	1.C,
8.00 a.m.	,		'											•		
SUB TOTAL							<u>.</u>								. *	
				_		24 HOURS	INTAKE =			OL	ITPUT =	1,3001	<u>u</u>			



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	Mr. ANANTHA KRISHNAN.
Date	

79/Mulc/MHI202381290

15/12/2023/IPH202302516

Name Dr.K.JAISHANKAR

TIO DE L'ANTINI DE L'ANTINI DE L'ANTINI DE L'ANTINI DE L'ANTINI DE L'ANTINI DE L'ANTINI DE L'ANTINI DE L'ANTINI Operation Performed :

. J CHART MH/ PRINT / 0061 / NRS IP No. :

Age

Date :

	TEMP	RESP	PUL	ВР	SP02	IV FLUID 1	ORAL	TOTAL	URINE	NGT	DRAIN	OTHER	DRUGS & MEDICATIONS			
9.00 a.m.	986	9	72	16/20	251		1000 J	20					TIME	DRUG	DOSE	RTE.
10.00 a.m.	asu.	28	74	120/60	971		70014								_	
11.00 a.m.	25.6	16	12-	Boho		,								Intake		
12.00 Noon	984	LB	ſ	120 80			HL		bool	Well	1	tion		- 21		
1.00 p.m.	280	16	,	nalco	J . 1		(œ	3.40	,					(AA)	4501	U
2.00 p.m.	agu	18	1	120/20										(i.f>	240H	
3.00 p.m.	વકુન	16	وا	130/76	95.1									MED -	, ,	
4.00 p.m.																
5.00 p.m.														TOTAL JUTAKE:	6904	
6.00 p.m.														, , , , , , , , , , , , , , , , , , , ,		
7.00 p.m.														Output:		
8.00 p.m.																
9.00 p.m.		_									ĺ			VAINE -	1,30	μĹ
10.00 p.m.															PASS	
11.00 p.m.															/	
12.00 MN									•					Total Oution	1 1/3	OMC
1.00 a.m.																
2.00 a.m.																
3.00 a.m.														NEHATNEBALA -	GIOR	L
4.00 a.m.																
5.00 a.m.																
6.00 a.m.													<u> </u>			
7.00 a.m.								 					ĺ			
8.00 a.m.																
SUB TOTAL			•					`		<u> </u>	•	•				
						24 HOURS	INTAKE =			0	UTPUT =					

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Medw	ay Ho	spitals®	
The way	i to bett	er health	

1	<u> </u>	<u>IX I</u>		1011 17 17 17 17 17 17 17 17 17 17 17 17 1
Date : 22 12 23		<u> </u>	IP No. :	
ANANTHA KRISHNAN.P.N			``	
Nal 20 (Male (MH)20238) 470			Age :	Sex :
Орі 15/12/2023/ірн202302516				
Peri Dr.K.JAISHANKAR			Date :	23 112 12

	-,,,,,		JELLE				ren pr.K.JA	orna analigi	A TRADE SAN DE L'ESTA VILLA	ll <u> </u>			-	Date : <u>-2.3 [[/L]</u>		
	TEMP	RESP	PUL	BP	SP02	IV FLUID 1		194 818 mm no		<u> </u>	DRAIN	OTHER	_	DRUGS & MEDICATION	VS .	ı
9.00 a.m.							100	100					TIME	DRUG	DOSE	RTE.
10.00 a.m.									500			500			;	
11.00 a.m.			,		· ·		10.0	200			No. 1	î,	-			1
12.00 Noon						(1	10.0	300	•		37.7					
1.00 p.m.							,									
2.00 p.m.				·			100	400	500			1000		FOTAL INTHER		
3.00 p.m.														.4 · · · · · · · · · · · · · · · · · · ·		
4.00 p.m.			[100	500			ĺ			1900 M		
5.00 p.m.			,	,						-						
6.00 p.m.							200	400	400			1400		TOTAL OUTPOT:		_,
7.00 p.m.			, ,				300	tnoo						2000m/		
8.00 p.m.																
9.00 p.m.							300	1300	300		1	1700				
10.00 p.m.	<i>/</i> -			1			200	1200						-	l	
11.00 p.m.																
12.00 MN		L														
1.00 a.m.																
2.00 a.m.	-						200	1700								
3.00 a.m.]				T		-							
4.00 a.m.		_				_										
5.00 a.m.	-								_							
6.00 a.m.							200	1900	300			2000				
7.00 a.m.									_				_			
8.00 a.m.				_					_							
SUB TOTAL												-				
						24 HOURS	INTAKE =	1900	o m	O	UTPUT =	200	lm c			







Every heart beat counts

Mr.Anantha Krishnan.p.n

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAJSHANKAR

Department of Dietetics NUTRITION ASSESSMENT AND CARE PLAN FORM

2008 800	ergies: Yes/No,	yes, specify	☐ Eggeta	arian"	
	_	•	│	arian" 📗	
et Prescription:					Jain
1907 2 (O) 1900 (1 CO) 200 (1 CO)	jatty	dab.	try sof	biles 3	dut.
BJECTIVE GLOBAL ASSESSMENT (ADULTS)	·		,		•
(A) Patient's related Medical History	<u> </u>				
1) Weight Change (overall change in past 6 months)	• •			. <i>j</i>	
	□3		□4	•	B 5
No weight change/ <5% gain	5 - 10%		10 - 15%	7";	>15%
2)1 Dietary Intake Duration	<u> </u>		· · ·	1	
	3		□4		□ 5
Oral No change Sub - optimal solid diet	Full liquid moderate overall de		Hypo - cale liquid diet		Starvation
Enteral / Adequate / Sub-optimal Parenteral Excessive Nutrition	Inadequa		Typo - cak	oric	Starvation
	!				<u> </u>
3) Gastrointestinal Symptoms Duration:	3			-	
No symptoms Nausea	Vamiting moderate		Diarrhoea	·	. severe anorexia
	symptom				
· · · · · · · · · · · · · · · · · · ·	Muri Llog	-	.		
	0;		,		□ 5 ,
None //mproved Difficulty with ambulation		culty with nal activity	Ught :	activity	Bed / chair,- ridden with no or little activity
5) Co - marbidity (Disease and its relationship to nutrition requirements)	,		,	,	
	فر آ	A CONTRACTOR OF THE PARTY OF TH	□ 4	<u>-</u>	5
Healthy Mild co- morbidity		foderate co - morbidity/ age >75 years	seve mort	re co- pldity	Very severa multiple co - morbidity
B) Physical examination	l				• • • • • • • • • • • • • • • • • • • •
Decreased fat stores or loss of subcutaneous fat					
					s
. Normal Mild	Model	ate			Severe
2) Sign of muscle wasting					
			□ 4.		□ 5
Normal Mild	Moder	ite			. Severe
Total Score = Sum f above 7 components	•		•		
Nutritional Status: Based on this patient is		·			· ·
Well Nourished	□(7 to 14)		<i>(2</i> (3)		
Moderately Mainourished	(15 to 18)		(12)		
Severely Malnourished	(19 to 35)				
Nutridon Intervention:					
Author arestaut.	1		☐ Parenteral		
Dord.	☐ Enteral				
	☐ Enteral				
Dora		☐ Fort - night		☐ Monthly	

Maria Catherine John Ppn
Senior Dietitian

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
Whichy	A sayean sed gutleman came sob	:
14180	and executed kelos	
	arrived to be were pourshed or leve	Suest
	by sup.	
Par T	: Kleb = Anton cur Brainia.	
	Patient wind b Cow- Educated to	
	patrit as family a person wid	
	or coppe or man Im	Maria Catherine Josh Senior Dietitian
	Tramin verties.	
blish, voico	Dut rody cate and clay cation does vot of the cate were	Maria Catherine John Senior Dietitian
19/12/h	hostotid to cost when. Oral witche in	crin Sohio Sehior Dietitian
10,00	Oral vitale in good. Educated the patient and family on 1600 caloning by fat or discontinuous dut or discontinuous distribution distrib	les (A)
	Empfid a small font med to go	Senior Digitial



Mr.Anantha krishnan.p.n

79/Malc/MHI202381290

15/12/2023/IPH202302516

Dr.K.JAISHANKAR

ELLBEING REPORT

Date: (1/12/23

Time: 1.15 pm.

Unit: (\\

Clinical diagnosis: Levere archic Menons

Surgery/ Procedure:

Memory decline, I sleep l'in), lou întreet. Impression:

- calm affect, responsive, no uge contact - I volcep & appetite (N) - multiple physical c/o { family health - stressors. memory decline (: Tyrans). Menory registering have been inggested for family, encouraged to provide prontère déficuations.

Employee ID: HH10275/PS4

Signature of the Psychologist:





Mx.ANANTHA KRISHNAN.P.N

79/Male/MHJ202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 15.12-25 Time of Arrival: 13.15 Mode of Admission: Walking Wheelchair Stretcher						
Accompanied by Relative: Tres No If Yes, Name of the Relative: MR. NAPPYBNAN.						
Relationship with Patient: ReviteD Contact Person's Name: MP NAPPYANARelationship: Sov						
Contact No.: Primary language spoken: Tamil English Indian International						
Interpreter needed: Yes No						
Patient status: Conscious Unconscious Disoriented Patient Vulnerable: Yes No						
Menstrual History: LMP: Menopause:						
Medical History: DM / HTN / Co - Morbility: DM / HTN - Yes If yes specify						
Drugs History : Antiplatelet (Specify)						
Psychological Status: Dealm Anxious Withdrawn Agitated Depressed Sleeping Difficulty						
Do you have any special religious, spiritual or cultural needs to be considered? Tes						
If Yes, specify details:						
Socio Economic Status: Employed Retired Own Business Home-Maker Others:						
Vital Signs: Temp: 42.1 (°F) Pulse / HR: 104 (beats/min) BP: 110 / 62 (mmHg)						
Respiration: 29 (breaths/min) SpO ₂ : 93/ (%) CBG: 120 (mg/dl) Height: 129 (cms) Weight: 60 (kgs)						
Allergies / Adverse Reaction: Yes Medication Blood Transfusion Food Not known						
If Yes, specify:						
Pain: Yes No. If Yes, Score: Plan 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 Change						
Last 3 months Weight:						
Type of Patient:						
Dietician Informed: Yes No. If Yes, mention the Name: MS. Catherine. Time: 19.15.						
Orient Patient if: Unconscious Unconscious Disoriented						
Poem Side Ratis Toilet Bell Patient Information Board Deathroom Bed Controls						
Use of Footstool Grab Bars Nurses Call Bell Television Light Controls Telephone						
Functional Assessment:						
Particular Assessment Remarks Outcome						
Visual Impairment Yes 140						
Hearing Impairment Yes \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \						
Chewing Difficulty Yes No						
Walking Difficulty Yes No						

Daily Activity Of L	.iving:					•				
Activity		Independe	ent		ssisted		_	Dep	ende	nt
Bathing										
Dressing			7						$\overline{\Box}$	
Eating			7							
Walking			,	_					$\overline{\Box}$	
Toilet Use					- -			-	$\overline{\sqcap}$	
Pressure Injury R	isk Asses	sment: Brad	len Scale		. ,			;		
Sensory Percep		Score	. Moisture		Score	Degr	ee of A	ctivity	,	Score
No Impairment	$\overline{}$	4	Rarely Mois	t	4		Freque			4
Slightly Limited		3	Occasionall	y Moist	3	Walks	occas	ionali	у	3
Very Limited		2	Very Moist		2	Chair	Fast			2
Completely Limit	ed	1	Constantly	Moist	1	Bed F	ast			1
Mobility		Score	Nutrition		Score	Fricti	on & S	hear		Score
No Limitation		4	Excellent		4	No a	oparent	probl	erta	3
Slightly Limited	<u> </u>	3	Adequate				tial Pro		•	2
Very Limited		2	Probably in-	-Adequate	2	Probl	em Pre	sent		1
Completely imme	obile	1	Very Poor		1					<u> </u>
High Risk: 12 - 10; Severe Risk: 9 - 6 Total Score: Action needed: Yes No Pressure injury present at the time of If yes, Location: Grade: Signature: Relation							Size:			
	MODIFIED MORSE FALL ASSESSMENT SCALE (Age above 16 years)									
Fall Risk Assess	sment (Mo	odified Mors	e Scale):		* *				•	
Variables								1	Nun	neric Value
History of falling	(immediat	e or within 6	months)				L	No		0
								Yes		25
Secondary diagr	nosis (≥ 2	medical diac	nosis)				<u> </u>	No		A
	•							Yes		(15)
Ambulatory Aid		naiat								0
None / Bed Rest Crutches / Cane		SSISI								(15)
Furniture	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,					 -			30
					_			No		0
Intravenous Ther	apy / Hep	arin Lock / 1	ubes insitu					Yęs		20
Gait						•				\propto
Normal / Bed Rest / Wheel Chair							_	\longrightarrow		10
Weak Impaired										20
Mental Status										
Oriented to own stability							İ			6
Overestimated o		mitations				-				15
Medications										
	Includes PCA / opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, hypoglycemics, sedatives, immunosuppresent and psychotropics							No		A
	•			<u> </u>	<u>.</u>	T		Yes		19/
Score Interpretation	1: U-24: LOV	v-risk; 25-44: N	vieaium Hisk; Ab	ove 45: High I	1ISK	Total S	core		!	45

As per the score, tick the following appropriate boxes: Low Risk Interventions (0-24) Familiarize the patient with the immediate surroundings Remind the patient to use call bell before getting out of bed Keep the two side rails in the raised position at all times for all patients regardless of age Keep the call bell, bedside table, water, glasses within the patient's easy reach Remove excess equipment or furniture to make a clear path Keep the patient's bed in the low position at all times except during procedure Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed ☐ Bed wheels should be locked Encourage family participation in the patient's care Ensure that floor of the bathroom is dry and not slippery Review medications for potential side effects that can promote falls Use safety belts during movement in wheelchair The patients are not ambulated by themselves. They are to be ambulated only with assistance Medium risk interventions (25 - 44) Apply all the low risk interventions Tie yellow fall risk tag in the bed and Wheel chair / Stretcher Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat Use restraints and bed monitors as ordered by the doctor Allow the patient to ambulate only with assistance Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care Do not leave patients unattended in diagnostic or treatment areas Accompany the patient while going to bathroom Advice the patient to use grab bars near the toilet, bathtub, and shower Make sure the family and other visitors understand the restrictions mentioned above High-risk interventions (above 45) Apply all the low and medium risk interventions Tie red fall risk tag in the bed, wheel chair and stretcher Locate the high-risk patients in a room close to the nurses' station Answer these patients call bells as quickly as possible Provide a commode at bedside (if appropriate) Urinal / bedpan should be within easy reach (if appropriate) ☐ Encourage family members or other visitors to stay with them If appropriate, consider using protection devices: safety belts Initial Assessment to Special Needs and Vulnerability of Patient: Yes Remarks (please specify) No Terminally ill patients Patients with intense chronic pain Woman in labor or experiencing termination of pregnancy Patients with emotional or psychological distress Patient suspected of drug or alcohol dependency Victims of abuse and neglect Patients whose immune system is compromised Patient with infections and communicable diseases Does the patient have implants Has tracheotomy been done Has colostomy been done Any other potential needs of the patient

DVT RISK ASSESSMENT Assign a score of 1 if (YES) in parameter nos. 1 to 9, and assign a score of -2 if (YES) in parameter no. 10 S. No. **Parameters** Yes / No Score Active cancer (on-going treatment or diagnosed within 6 months or palliative care) 1 Yes No 0 0 2 Bedridden recently >3 days or major surgery within four weeks Yes No Ð Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle 3 Yes No (Assess for both legs) 4 No Collateral (nonvaricose) superficial veins present (Assess for both legs) Yes О 5 Entire leg swollen (Assess for both legs) Yes O No 6 0 Localized tenderness along the deep venous system (Assess for both legs) Yes No 7 Pitting edema, greater in the symptomatic leg (Assess for both legs) Yes P No 0 8 Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs) Yes No 0 9 Previously documented DVT (Assess for both legs) Yes ^No 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) 10 Yes O 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): Final Score 0 Tick the score obtained (✓) Time **Action Taken** Date Low Risk -2 to 0 15/2/13 19.30, Moderate Risk 1 to 2 High Risk 3 to 8 Personal Belongings / Valuables: Name & Signature of the With With Patient's Description Valuables Remarks Patient / Patient's Attendant **Patient Attendant** □ Upper □ Lower Dentures □Both □Nii □Right □ Left **Hearing Aid** Eye glasses / DAY0 ☐ Yes **Contact lens** Jewellery ☐ Yes Other valuables (specify) Report (List of X-ray, ECG, lab reports retained with the nurse): Emp. No. Date Time Sign. Patient / Relationship Patient's Attendant Sow Nurse 0162 Unit In-Charge 10002





MI.ANANTHA KRISHNAN.P.N

79/Male/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





Date: 15	112/2	3 Shift: ☐ Morr	ning Levening Night			
S	Ventilator Periphera Ryle's Tu	day: — Lef line day: Right: Lef be: Yes Live Day atheter: Yes Jive Day	rese Calcific A0871 GCS: 1/18 POD: Central line VIP Score: R: Yes Mo. If Yes, specify organic	days: - '	?'MT , C	er-
В	Type of s Allergies On room	round urgery: — if any: Incuever air / oxygen: B & em nts / New Symptoms in last s			··	;
		ns: Temp: <u>¶& (</u> °F) Pulse	/ HR: 99 (beats/min) Respira			
Λ	Others :	ore: Olo Pain Scale used	<u>6</u> (%) Height: <u></u> 1 (cms) Weight: 	•	j	,
	Pressure	•	At Risk-Mild Risk: 18-15 ☐ Moderate Ri SH): ☐ Yes ☐ No ☐ NA			. ,
		IMENDATION				
		doctors: Ualtro Opt	ionol.			
]	_	medications:				
	Pending	medication indent:	Donnes Her,	Hbeas, PT 19	NR	
H	Critical v	alue alert and its corrections:	periporismea, HCV, UTNE CK	·		
			No. If Yes, modified care plan date			}
	Pending	follow-up orders: Crack	tro			
	Special in	nstructions if any:	O CRC, RFT, LF	Tommot, Tommo	N,	
<u></u>		Signature	Name	Emp. No.	Date	Time
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Handover ta	aken by	Correct.	madhemetha.	ALA QO	16/12/27	19-20
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	Signature	Name	Emp. No.	Date	Time
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Mr.Anantha krishnan.p.n

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.Jaishankar



Every heart beat counts

	FAIIE	INT CLINICAL	HANDOVEN NECON	D FOR NOR	IJEJ				
Date: 15	112/2	_3 ' Shift: ☐ Mor	ning Evening Night		,				
S	Ventilator Periphera Ryle's Tul Urinary C	day: al line day: Right: CP Ce be: Yes No Da catheter: Yes No Da	GCS: 15 POD: Central line ay: VIP Score: ay: DR: Yes No. If Yes, specify organ	days: _	nÓsis ,				
В	Òn room	urgery:	Date of surg DOM OUS IV fluids on shift:						
A	ASSESSMENT Vital Signs: Temp: 9 78 F) Pulse / HR: 8								
R	Referral of Pending Pending Pending Critical vo Changes Pending	alue alert and its corrections in nursing care plan: Yes follow-up orders:	CBC, LFT, RFT, HBCA						
		Signature	Name	Emp. No:	Date	Time			
Handover (given by	<u> </u>	laghunithos	02 HH	16/12/23	4.30			
Handover 1	aken by	why	R. Whancey.	2352	16/14/28	7,80.			
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NURSES PROGRESS NOTES								
Date & Time	Observations / Action	Signature with Emp. No.						
15/12/23	Pt hand a vol taken from	_						
a) 19.45	evening duty Stapp. Pt							
	on from ois. Pt was							
	homodymically dtable.							
	P+ Try. Pan - 4ml/hg- and Pry. lacin-2ml/h							
	on Plan. Fluid lestaition 1-1:5 https:/	m 02 ht H.						
20.10.	Bry. H.A- H S/C given.							
20.30	P+ modication and							
	dinner taken.							
20-40	P+ medication given as							
	Pol drug chart.	02H7.						
21.00	pt V/g are checked	021(7.						
	and recorded.							
22.00	P+ was gleeping,							
DO- 600	Pf V/S ale checked	02AH						
	and lecolded.							
4-00	Mosning dample							
	Jahan.	7,5						
5.00	Mosning Cara given	oun						
6,00	ECO and CB a taken							
4.00	It VIS are checked	0)41						
	and hewroled P+ voided motion:							
7-30	Pt -hound, gus to							
	mosning outy Staff	02 11 h.						
	<u> </u>							
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Mr.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





DATIENT OF INICAL HANDOVED DECORD FOR MIDSES

	FAII	INT CLINICAL F	IANDOVEN RECOR	D FOR NOT	いしし	
Date: (6/	12/2	3 Shift: Morr	ing Evening Night	; , , ,		
S	Utilially C	ameter. 🗀 tes 🗀 tvo 💛 Day	ing Evening Night Column Acon Sen GCS: Sen POD: — Central line VIP Score: R: Yes No. If Yes, specify organi		Cest.	
В	On room					
A	Others: Pain Sco Fall Risk Braden S	re: O Pain Scale used Score: Minimal Risk: 23-19 [Ulcer Scale for Healing (PU:	/ HR: / / / / / (beats/min) Respir 5 (%) Height: / / / / (cms) Weight : PIPPS / CRIES / FLACC / Wong-Ba ptocol: Low Medium High At Risk-Mild Risk: 18-15 Moderate R SH): Yes No NA Wound I Drain	ker FACES Pain Ratir sk: 14-13 High Risk: Dressing done: Yes	<u>O(·S</u> m ^P ng Scale /NRS	S / CPOT
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	gni.		To send	By Augus
		Signature	Name	Emp. No.	Date	Time
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	NURSES PROGRESS NOTES						
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Mr.ANANTHA KRISHNAN.P.N

79/Male/MHI202381290 15/12/2023/IPH202303516

Dr.K.JAISHANKAR





Date: 16 12	23	Shift: Morn	ing Evening N		:	,	
S	NEWS / F Ventilator Periphera Ryle's Tul	al line day: Right.	<u>!</u> :	POD: 15 15 Central line of VIP Score: 0	ays: —	整/207	
В	On room			Date of surge	i		-
A	BP: 65 Others: Pain Sco Fall Risk Braden S Pressure	ns: Temp <u>97-) (</u> °F) Pulse	b (%) Height: ±168 (c : PIPPS / CRIES / FLAC : Dtocol: ☐ Low ☐ Mediu ☐ At Risk-Mild Risk: 18-15	ms) Weigḥt: ₫ C / Wong-Bake m ∐Hīgh] Moderate Risl	er FACES Pain Ratin c: 14-13 High Risk: ressing done: Yes	N.313 m ² ng.Scale / NR 12-10 □ Seven	
R	Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: nstructions if any:	SUME.			ed. Prote TC, DC	ا مرکز
Handover giv	ven by	Signature .	Name S. Allinym	rec	Emp. No.	Date 16 12 23	Time 19.80
Handover tal	ken by		Promalatho		0211	16/12/23	19.30
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NURSES PROGRESS NOTES						
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19:30	- Concentration	ingover to NPgh	+ dots	<u> </u>		
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Document	Signature	Name	Emp. No.	Date Time		
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Mr.Anantha Krishnan.P.N

79/Male/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





	PAHE	INI CLINICAL I	HANDOVER REC	אט דטא ויטו	HOE9	
Date: ₫	6/12/	9.3 , Shift: ☐Mor	ning Evening Might			ľ
S	Ventilator Periphera Ryle's Tu Urinary C	Catheter: 🔂 Yes 🔲 No 👤 Da	GCS: POD: Central ft: CODACC .	NS_LISV I line days: ore:0/5	etic &	fenoka,
B	Allergies On room	ROUND urgery: — if any: NKIDA air / oxygen: O other / New Symptoms in last s	1 voa fm IV fluids	s on flow: $\sqrt{1}\sqrt{1}$	nj Alb	amen
A	BP: 112 Others : Pain Sco Fall Risk Braden S	ns: Temp. 97 / (°F) Pulse Social Content Pulse Pain Scale use Score: Fall Risk Pr Score: Minimal Risk: 23-19 Ulcer Scale for Healing (PU	HR: 80 (beats/min) R (%) Height: 1/6 (cms) Wo d: PIPPS / CRIES / FLACC / Won otocol: Low Medium High At Risk-Mild Risk: 18-15 Moder ISH): Yes No DNA Wo	g-Baker FACES Pain Ráti jn ate Risk: 14-13 ☐ High Risk	21.3 kg ing Scale (NF : 12-10 Seve	ns ACPOT
R	Referral of Pending Pending Pending Critical volumes Changes	medications: medication indent: lab reports / Investigations: alue alert and its corrections	WWW (189 SH AMON) SHER Platol WHO. If Yes, modified care plan	t court at court a date:	IA, nietūę	oumin/7c/
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NURSES PROGRESS NOTES							
Date & Time		Observations / Action		Signat	ure with En	np. No.	
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@ 19.30	Pt takon	war board pour	1000		Ø		
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Pal Mr. ANANTHA KRISHNAN. P. N

Na 79/Malc/MHI202381290

UF 15/12/2023/IPH202302516

DC Dr.K.JAISHANKAR

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Every heart beat counts

PATIENT CLINICAL	HANDOVER	RECORD	FOR NURSES
PATICIAL CLIMICAL	HANDUVEN	NECOND	FUR NUNSES

	. 7111		MINDOVEIL	······		IOLO
Date:	12/23	Shift: Morr	ning Evening	Night		
S	Ventilator Periphera Ryle's Tul Urinary C	al line day: Right. <i>Opholi</i> iLet be: ☐ Yes ☐No Day atheter: ☐ Yes ☐No Day	n cephalic	Central line d	lays: -	
В	On room			Date of surge		
A	BP: 36 Others: Pain Sco Fall Risk Braden S Pressure	ns: Temp <u>q<i>β</i>·4</u> (°F) Pulse <u>} {Q.(</u> mmHg) SpO₂: <u>q</u> }	2_(%) Heighti] 68 I: PIPPS / CRIES / FLA otocol: □ Low□ Med	(cms) Weight <u>r</u> CC / Wong-Bak ium ☑High 5□ Moderate Ris	er FACES Pain Rat k: 14-13 ☐ High Risk ressing done: ☐ Ye	ting Scale / NRS / CPOT
	Referral of Pending Pending Pending Critical vo Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders: mstructions if any:	Vaine cls lept : Imotein; Uno. If Yes, modified	og L- , Sq Albixmur I care plan date	-Amonia, , 176106 1 :	Autic Fluid 82.AFB.
		Signature	Name		Emp. No.	Date Time
Handover (given by	Alre	e Muth	•	0282	17/12/28 12.00
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cument	endorsed	Jaye	JAYA199	ew)	000	197/2/24 13-0
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	NURSES PROGRESS NOTES	
Date & Time	Observations / Action	Signature with Emp. No.
17/15/13	3 MORNING DUTY REPORT	
10/10		
J.30	Pt Repost tuken from night duty	Armi
	SIN, pt 28 conscious a oriente	0280
	pt vitals are monitoring.	
8.30	pr- take dist & morning drugs	100
<u></u>	are gluen pre have complaint	Dez
	of longuating.	
12.00	pi- on consineras condiae	•
1 2 0 0	monitoring there is no any	Ahry
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	USSINIS :	
10 00	Matron - Report No ro afternoon	-12-8
13.00		- 5282.
	duty SIN-	- 5202
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	Signature Name Emp. No.	Date Time
Document endorsed by	Harri TAYADEN I DOO	1- 1-112/23/1450

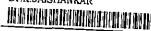




Mr.Anantha Krishnan.p.n

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





Every heart beat counts

Date: 17	12 23.	Shift: Morr	ning Evening 🗓	Night		-	
S	Ventilator Periphera Ryle's Tut Urinary C	l line day: Right. Cortellor De: ☐ Yes ☐ No Day atheter: ☐ Yes ☐ No Day	coptalic.	Central line o	lays: -)(5		1
В	Allergies i	ROUND urgery: if any: NKDA air / oxygen: QUHE OA ts / New Symptoms in last s		Date of surge	•		*
A	Others: Pain Sco Fall Risk Braden S Pressure	SMENT ns: Temp 97 & (°F) Pulse 1	/ (%) Height: 68 (6 : PIPPS / CRIES / FLAC Docol:	cms) Weight: CC / Wong-Bak um []}High [] Moderate Ris	ker FACES Pain Ratin sk: 14-13 High Risk: Dressing done: Yes	21-31-21M ng Scale / NR 12-10⊡ Sever	
R	Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: MUE medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: instructions if any: 7000	: DNO. If Yes, modified	•	x:	•	
Handover g	iven by	Signature	Name E. Allewig from	opiale	Emp. No.	Date	Time 19.30
Handover to		Jaye	& Personalat	m Lest)	000	17/12/23	19:20

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Date & Time		Observations / Action		Signa	ture with Er	np. No.
1412/22						
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Mt.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





Date: ነ ች(2/23.	Shift: Morr	ning Evening 🛂	Night		,	
S	Ventilator Periphera Ryle's Tu Urinary C	al line day: Right (a) holi (Lef be: ☐ Yes ☐ No Day atheter: ☐ Yes ☐ No Day	r:ceprolic	Central line days:	, i · · · · · · · · · · · · · · · · · ·		
B	Allergies On room	round urgery: if any: NKDA air / oxygen: 5 Utoul ats / New Symptoms in last s		Date of surgery: IV fluids on flow:	 		
A	BP: 1128 Others: Pain Sco Fall Risk Braden S Pressure	ns: Temp: <u>Q</u> &_(°F) Pulse <u></u>	(%) Height: \\ (0) (0) (0) (0) (0) (0) (0) (0) (0) (0)	cms) Weight:(C / Wong-Baker FAC untHigh Moderate Risk: 14-13	kgs) BMI: 0 ES Pain Ratin : □High Risk:	<u>1.8 kg</u> m g Scale ⊬.₩Rf 12-10∐Severe	S/CPOT
	Referral of Pending Pending Pending Critical von Changes	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders: mstructions if any:	: □ No. If Yes, modified	•	C,RFT o	LFT (R) duo
<u> </u>	_	Signature	Name	Emp.	No.	Date	Time
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NURSES PROGRESS NOTES						
Date & Time		Observations / Action		Signature with Emp. No.		
17/11/83	Night	duty Notes	-			
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Mr.ANANTHA KRISHNAN.P.N

79/Male/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





Date: 18/19	las.	Shift: Morn	ing Evening Night						
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	SITUATION Diagnosis: TODIN SHITN SEVELE CALCHIC FOR PORTIC SHENOWS Diagnosis: TODIN SHITN SEVELE CALCHIC FOR PORTIC SHENOWS NEWS / PEWS Score: Ventilator day: Ventilator day: Peripheral line day: Right: OP Left: Ryle's Tube:							
B	On room			•					
A	ASSESSMENT Vital Signs: Temp: 97.8F) Pulse / HR: 64 (beats/min) Respiration: 94 (breaths/min) BP: 30 13 (mmHg) SpO ₂ : 99 (%) Height: 68 (cms) Weight: 60 (kgs) BMI: 01.3kg MO2 Others: Pain Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS CPOT Fall Risk Score: Depain								
RECOMMENDATION Referral doctors: Dr. Anarth Pending medications: NIL Pending medication indent: Pending lab reports / Investigations: TC / DC / Critical value alert and its corrections: Mr.ANANTHA KRISHNAN.P.N Changes in nursing care plan: Yes Mo. If Yes, modif Pending follow-up orders: Dr.K.JAISHANKAR Special instructions if any: Phon Label Mr.									
Handover (iven by	Signature	Name	Emp. No.	Date	Time			
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79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





Every heart beat counts

PATIENT CLINICAL	. HANDOVER	RECORD	FOR	NURSES
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Date: 10	1212	Shift: ☐ Mor	ning ☐ Evening ☐ Night		.020
S	SITUATI Diagnosis NEWS / F Ventilator Periphera Ryle's Tul	ON S: Sure Count is to PEWS Score: day: Il line day: Right: COP W Le De:	for Abortive Slungsig GCS: LST POD: Central line y: VIP Score	015	
B	Ou room		Date of surg IV fluids on shift:	•	
A	Others: Pain Sco Fall Risk Braden S	ms: Temp: (°F) Pulse Pulse Pulse Pulse	(beats/min) Respin (%) Height: 6 (cms) Weight d: PIPPS / CRIES / FLACC / Wong-Bar rotocol: 6 Low Medium High At Risk-Mild Risk: 18-15 Moderate R ISH): 9 Yes No NA Wound Drai	i:(kgs) BMI: uker FACES Pain Ratin iisk: 14-13	ng Scale / NRS / CPØT
	Referral of Pending Pending Pending Critical volume Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections	SINO. If Yes, modified care plan dat	te:	,
Handavara	iliyan bu	Signature	Name	Emp. No.	Date Time
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	NI	JRSES PROGRESS NOTES				ι
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Pai Mr.ANANTHA KRISHNAN.P.N Nai 79/Male/MHJ202381290

UHI 15/12/2023/IPH202302516

DOI Dr.K.JAISHANKAR DOY HANDING BUILDING



Every heart beat counts

		NI CLINICAL F	IANDOVER RECOF	ED FOR NUR	19E9	ľ
Date: (&	1/2/23	Shift: Morn	ing Evening Might		_	·
S	SITUATI Diagnosis NEWS / P Ventilator Periphera Ryle's Tut Urinary Co	ON SEWERE COLCHING EWS Score: day: I line day: Right: Left De: Yes No Day atheter: Yes No MD	Jos a patte steriosis GCS: 15 POD: — Central line VIP Score R: Yes No. If Yes, specify organ	[5 e days: — O [5 nism: —	•:	
B	On room				-	
A	BP: \\ \(\begin{align*} \text{Others:} \\ \text{Pain Sco} \\ \text{Fall Risk} \\ \text{Braden S}	re: Olio Pain Scale used Score: Minimal Risk: 23-19 Ulcer Scale for Healing (PUS)		nt: <u>60</u> (kgs) BMI: <u>o</u> aker FACES Pain Ratin	Rh3kg ng Scale / NR 12-10⊡Sever	S. / C POT e Risk: 9-6
R	Referral of Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	N() □No. If Yes, modified care plan da	ate:		
		Signature	Name	Emp. No.	Date	Time
Handover		<u>A</u>	A. Anitha	0222 /	19/12/23	1-30
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	NU	JRSES PROGRESS NOTES		_		
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79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR THE REPORTED HER REPORTED HER REPORTED HER HER THE



. ·	PATIE	NT CLINICAL H	IANDOVER REC	CORD FOR NUF	ISES	
Date: 10	112/23	Shift: Morr	ning Evening Night			•
S	Urinary C	atheter: Yes 16 No Day	t: whalic Cen	0/5		
В		urgery:	r IV flu	e of surgery:		
A	BP: 136 Others: Pain Sco Fall Risk Braden S	ns: Temp: 9 f. 2 (°F) Pulse O O (mmHg) SpO ₂ : 9 O Pain Scale used Score: Fall Risk Pro Score: Minimal Risk: 23-19 Uicer Scale for Healing (PU	<u>(</u> 9 (%) Height: <u>/68</u> (cms) 	Respiration: <u>&</u> (breat Weight: <u>& o</u> (kgs) BMI: Yong-Baker FACES Pain Ratin High derate Risk: 14-13 High Risk: Wound Dressing done: Yes Drains:	<u>21. Sky</u> M ng Scale / NR 12-10⊡Severe	≶∕/ CPOT
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections	∬No. If Yes, modified care p	olan date:		
,	- *	Signature	Name	Emp. No.	Date	Time
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		one and extental	ion		
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79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





Every heart best-counts

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PATIENT	CLINICAL	HANDOVER	RECORD	FOR NURSES

		NT CLINICAL F	IANDOVER I	RECORI	D FOR NU	RSES	'
Date: 20	12/23		ning Evening D		_		
S	Ventilator Periphera Ryle's Tut Urinary C	ON SIGNERE. COLUMIC OF SEWS Score: day: I line day: Right: De: Yes No Day atheter: Yes No Day ursing: Yes No MD	osttic stenosis :: ophalic :: :: R: □Yes □No. If Yes, :	Central line of VIP Score:	0 (5		
В	Allergies i On room	ROUND urgery: ー if any: ハドカラ air / oxygen: 足ののか が its / New Symptoms in last s		Date of surg			
Α	BP: 130 Others: Pain Sco Fall Risk Braden S	re: O(O Pain Scale used Score: Minimal Risk: 23-19 Ulcer Scale for Healing (PU	(%) Height: 16 & (: PIPPS / CRIES / FLAC otocol:	cms) Weight: CC / Wong-Bak um	er FACES Pain Rates: 14-13 High Risk 14-13 One: Ye	all 3 kg/n ting Scale / NRS c: 12-10 Severe	S <i>J</i> -CPOT
R	Pending Pending Pending Critical va	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:)	care plan date	:		
		Signature	Name		Emp. No.	Date	Time
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	~	HHT DUTY notes	3	
19.30	g patient h	and over taken ning duty state	le shi	
		onscious eural oni	7	
20.00	→ medications	n given as P	ر در	
81,00	> Mebulice	bion given to f	he pt A	
22.00	& Patient ha	emodynamically s	tab re	
స్ట్రీస్త్రం	> pt sleep	well	Ø	22
5.00	7 pt vital	signs checked		
6.00	> I/o Charl	monitored over given	-10	
1.30	p Pt hand modning	d over - given	Ai 027	, ν
		i		
	Signature	Name	Emp. No.	Date Time
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Paij Mt.Anantha Krishnan.p.n

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UHI 15/12/2023/IPH202302516

DOI Dr.K.JAISHANKAR





F	PAŢIE	NT CLINICAL F	IANDOVER RECOF	ID FOR NUF	RSES	
Date: ೨೦(12(25	Shift: Morn	ing Evening Night			
S	NEWS / P Ventilator Periphera Ryle's Tul Urinary C	PEWS Score: O day: — Il line day: Right: Left be: ☐ Yes ☐ No Day atheter: ☐ Yes ☐ No Day		days: —	;	
В	On room					
A	BP: 120 Others: Pain Sco Fall Risk Braden S	re: Old Pain Scale used Score: Minimal Risk: 23-19 [Ulcer Scale for Healing (PUS		it: 🔥 (kgs) BMI:_	<u>Ql, Skg</u> l ng Scale / NR 12-10⊟Severe	S/CPOT
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Mr.ANAN (A KRISHNA) .N 79/Male/MHI202381290 15/12/2023/IPH202302516





PATI	ENT CLINICAL H	HANDOVER RECOR	D FOR NU	RSES	
Date: 00/12/1	Shift: Morr	ning	·	· 	
NEWS / Ventilate Peripher Ryle's Ti Urinary	ris: 8 € 00 P} PEWS Score: or day: — ral line day: Right:	y: VIP Score: ^C	76	•	
Type of Allergies On room	Surgery: s if any: o of (ANO on air / oxygen: o nair / oxygen: o nair / oxygen: o nair / oxygen: o nair / oxygen: o nair / oxygen: o nair / oxygen:	ခေတ်က IV fluids on f		- 	
Vital Signal BP: 102 Others Pain So Fall Ris Braden Pressur	eore: Pain Scale used k Score: Fall Risk Pro Score: Minimal Risk: 23-19	/ HR:(beats/min) Respire (%) Height: <u> 68 (cms) </u> Weight: I: PIPPS / CRIES / FLACC / Wong-Ball otocol: Low Medium High At Risk-Mild Risk: 18-15 Moderate Ri SH):Yes No NA Wound [ker FACES Pain Rat sk: 14-13	ing Scae / NF	S/CPOT
Referral Pending Pending Critical Change	MMENDATION doctors: g medications: g medication indent: g lab reports / Investigations: value alert and its corrections is in nursing care plan: Yes g follow-up orders:	No. If Yes, modified care plan date	e:	_	
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79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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Date:	2/12/23	Shift: Mo	orning Evening Ni	ght PFCF	IVINOH A	VOTE>_			
S	NEWS / P Ventilator Periphera Ryle's Tut Urinary C	S: BPH , DM, HTM PEWS Score: 0 6 day: Il line day: Right: be:	.eft:	GCS: ISIS POD: Central line days: VIP Score:	_	eputicep	lalopeth		
В	Allergies i On room	urgery: -	ree i	ENT Date of surgery:			•		
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79/Male/MHI202381290 15/12/2023/IPH202302516



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S	SITUATI Diagnosis NEWS / F Ventilator Periphera Ryle's Tul Urinary C	ON S: BPH DIM HTM PEWS Score: — day: Il line day: Right: — Lef be:	POD: Centra VIP So	al line days: — core: 0/5		
В	Allergies On room	ROUND urgery: ענוֹ / if any: ענוֹ / air / oxygen: על (كَالَ) its / New Symptoms in last s	lou g IV fluid	of surgery: Mi) is on flow: 501021HA		
A	BP: 130 Others: Pain Sco Fall Risk Braden S	re:Pain Scale used Score: Minimal Risk: 23-19 [Ulcer Scale for Healing (PUs	/ HR:	/eight:(kgs) BMl ng-Baker FACES Pain Ratir igh orate Risk: 14-13 □ High Risk:	ng Scale / NR	
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15/12/2023/IPH202302516

Dr.K.JAISHANKAR

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Α	BP: \\Lambda \\Lambda \\ \text{Pain Sco} \\ \text{Fall Risk} \\ \text{Braden S}	ns: Temp: 98.6 (°F) P	used: PIPPS / CRIE k Protocol: Lov	t:(cms) Weight: ES / FLACC / Wong-Bal v ☐ Medium	ker FACES Pain Rat sk: 14-13 High Risk Dressing done: Ye	ing Scale / NR	e Risk: 9-6
R	Pending Pendin	IMENDATION doctors: medications: medication indent: lab reports / Investigation alue alert and its correct in nursing care plan: follow-up orders:	tions:	modified care plan date	Đ:	_	
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Mr.Anantha Krishnan.p.n

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Dr.K.JAISHANKAR ALD REPORT FOR THE REPORT OF T

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ATIENT OF INICAL	HANDOVER	RECORD	FOR I	MURSES

PATIENT CLINICAL HANDOVER RECORD FOR NURSES	
Date: 2+(12/23 Shift: Morning Evening Night	
SITUATION Diagnosis: PPH MM HTM Diagnosis: PPH MM HTM Diagnosis: PPH MM HTM Diagnosis: PPH MM HTM SITUATION Diagnosis: PPH MM HTM GCSJULT POD: Central line days: Central line days: Peripheral line day: Right: Left: Ryle's Tube: Yes No Day: Urinary Catheter: Yes No Day: Barrier nursing: Yes No MDR: Yes No. If Yes, specify organism:	
BACKGROUND Type of surgery: Allergies if any: On room air / oxygen: MP-24785 Ab ₂ -96 Complaints / New Symptoms in last shift:	
ASSESSMENT Vital Signs: Temp 3-2 (°F) Pulse / HR: FO (beats/min) Respiration: P (breaths/min) BP:	.
RECOMMENDATION Referral doctors: MCHE CANION. 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:	
	ime
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	NURSES F	ROGRESS NOTES		<u></u>	
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The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)

15/12/2023/IPH202302516 Dr.K.JAISHANKAR

	PATIE	NT CLINICA	L HANDOV	ER RECOR	D FOR NU	RSES	
Date:	alikis	Shift: 🏹	Morning Evenir	ng Night			
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В	Allergies i On room	ROUND urgery: if any: air / oxygen: its / New Symptoms in I	ast shift:	Date of surg IV fluids on f			
A	BP: \\o\	re:Pain Scale Score: Minimal Risk: 23 Ulcer Scale for Healing	used: PIPPS / CRIES k Protocol: □ Low At Risk-Mild Ris	(cms) Weight: 6 / FLACC / Wong-Ba 1 Medium 11 igh 18:18-15 Moderate R	:(kgs) BMI: ker FACES Pain Rat isk: 14-13 □ High Risk Dressing done: □ Ye	ring Scale / NR	e Risk: 9-6
R	Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigation alue alert and its correct in nursing care plan: follow-up orders: instructions if any:	tions: -	odified care plan dat	e:	_	
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Pr MI.ANANTHA KRISHNAN.P.N Ni 79/Male/MHi202381290 U 15/12/2023/IPH202302516 D D Dr.K.JAISHANKAR ATRIAN DAN DIA MERANJAH MENTANDAN DIA MENANDAN DIA MENANDAN DIA MENANDAN DIA MENANDAN DIA MENANDAN DIA MENANDAN



Every heart beat counts

	PATIE	INT CLINICAL	HANDOVER R	ECORD F	OR NUF	RSES	
Date: 25	1/12/2		ning Evening N				
S	Urinary C	atheter: 🗌 Yes 🗐 No 🌙 Da		G			t .
В	Allergies On room	ROUND urgery: ー if any: ルドロච air / oxygen: Д 1 1005 nts / New Symptoms in last	` `	Date of surgery:	<u>[</u> .]	-	,
A	BP: 89 Others: Pain Sco Fall Risk Braden S	ns: Temp: 8 / (°F) Pulse 0 52 (mmHg) SpO ₂ : 9 ore: Oldo Pain Scale use Score: Fall Risk P Score: Minimal Risk: 23-19 Ulcer Scale for Healing (Pl	6 (%) Height: 16 € (ci d: PIPPS / CRIES / FLAC rotocol: □ Low □ Mediu ☑ At Risk-Mild Risk: 18-15 □	ms) Weight: <u>+ 6</u> C / Wong-Baker F/ m	oౖ(kgs) BMI: ျ	<u>21 · 3 kg</u> l ng Scale / NRS 12-10⊡Severe	S / CPOT
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:	s:	are plan date:			
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Mr.Anantha krishnan.p.n

79/Malc/MHI202381290 15/12/2023/IPH202302516





PATIENT CLINICAL HANDOVER RECORD FOR NURSES									
Date: 22	-/10/23	Shift: Morn	ing Evening 121	√ight •					
S	Ventilator Periphera Ryle's Tul Urinary C	s: DHD SeVOO Calc PEWS Score: 6 day: — Il line day: Right: — Left be: — Yes — No Day atheter: — Yes — No Day	HILL HOYUL	GCS:(S)(S) POD: Central line VIP Score: (Specify organic	days: _				
В	On room		·	Date of surg			÷		
A	BP: 126 Others: Pain Sco Fall Risk Braden S Pressure	ns: Temp: <u>96/J(</u> °F) Pulse) <u> 60 (</u> mmHg) SpO₂: <u>9</u>	(%) Height: <u>d 60</u> (0 :: PIPPS / CRIES / FLAC otocol: □ Low □ Medi □ At Risk-Mild Risk: 18-15	cms) Weight: CC / Wong-Bal uml.☑Hīgh □ Moderate Ri Wound D	<u> </u>	<u> </u>	S / CPOT re Risk: 9-6		
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:	ـا ا	care plan date	ə:	_			
	_	Signature	Name		Emp. No.	Date	Time		
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Dr.K.JAISHANKAR





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Vita BP: Oth Pali Fall Bra Pre	ners () in Scoll Risk aden S	re: Pain Scale of Score: Fall Risk: 23	ulse / HR: 80 (be 2: 96 (%) Height: 6 used: PIPPS / CRIES / F k Protocol:	LACC / Wong-Balledium High B-15 Moderate Ri	(kgs) BMi	i: ン(- 3(△) (¬) ating Scale (NR) sk: 12-10∐Seven	3 / CPOT e Risk: 9-6
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ADULT NURSING CARE PLAN

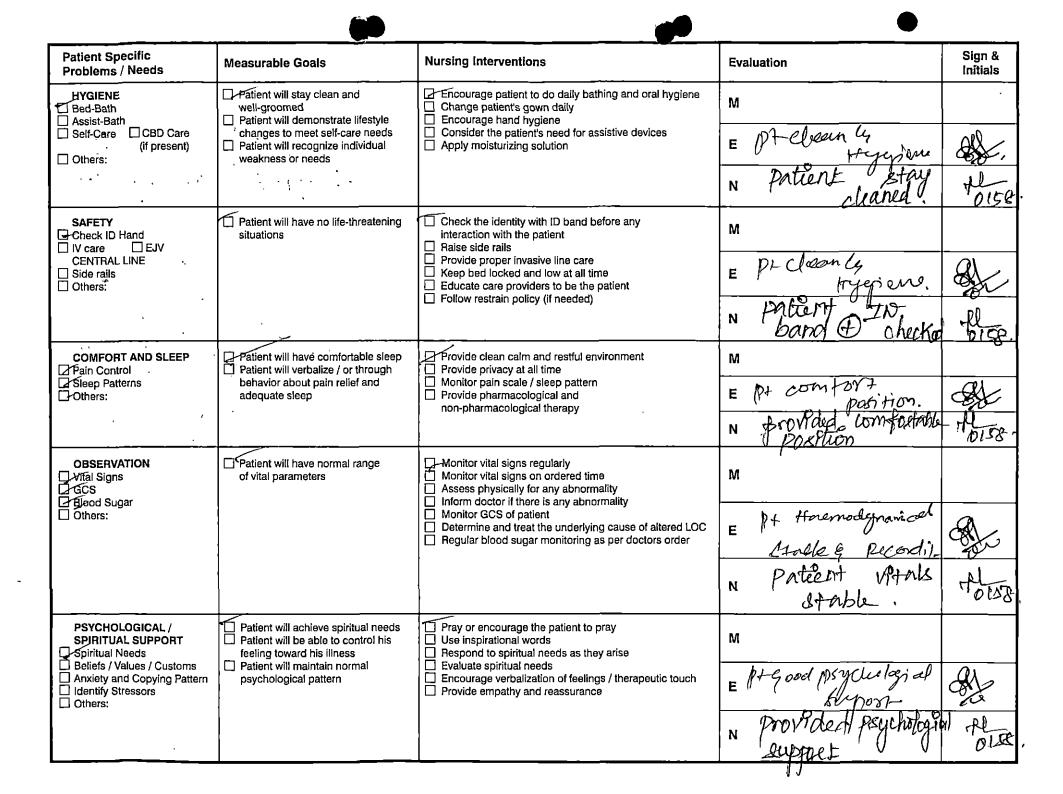
Mr.Anantha Krishnan.P.N

79/Male/MHI202381290 15/12/2023/iPH202302516



			<u> </u>	
Initial Date: 15/12/2	7 Time: 13-00	Modified Date: Time:		
Reason for Modification:		Diagnosis: TODM / HTN/ SEVE	BRE ADRIC STENOSIS /2U	MI KER
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep-NPO ☐Negular Diet	☐ 'Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	М	
Others:	requirements in accordance to his activity level and metabolic needs	Necord amount or lood consumed	E Athad. DM dill.	:28
			N patient had dinney	. HO158
OXYGENATION 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	М	
☐ 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	pt on on a litur	S
,		Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging patient with successful coughing	N patient spor maintained 991.	PLOISE
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	٠١
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 P+ tate a ord Elivers.	
· 	;	The state of the s	N patient of heid status was balanch	POLLE

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	М	
☐ 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 PH BED Mobilize Patient Wal	
		,	n patient alae bed mobilised	AD158.
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	М	
☐ 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 PHO celimination pattern pat	ON STATE OF THE PARTY OF THE PA
:		and follow proper protocol Check for malena / constipation / urinary retention	n patient chimination	Hota
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE	Patient will maintain normal healing status Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin	М	
INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased		Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	p+ Maintain @ E Picin Enternity	ST.
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			patient skin integrity .	10158



☐ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	Patient will communica with positive feedback To manage on time	te effectively	Introduce the care giver Encourage the use of call bell Obtain interpreter if needed No negative speaking about the patie or prognosis in the patient's presence Double check for high alert medication of the provide proper measures of wound complete proper measures of wound complete proper measures and protocols and explain to the patient / family	eaction are	M E M 5000 Mainta Mougautic M	wartal mnunication ined good selationship	Al
☐ Medication ☐ Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion	To manage on time		Observe and report any medication rule. Provide proper measures of wound composite projects and protocols.	eaction are	1 10 100	1	
DVT Management Others:			□ Check for cross matching and typing compatibility □ Practice strict asepsis while transfusir blood products and fluids □ Monitor DVT score and continue treat as per doctors order	, to ensure ng blood or	E planinisa nedica n patient given as	moderation	Black
Signature		Name		Emp. ID	U	Date	Time
Endorsed by	Son Son	Jae	por!	000	2_	15/10/23	81.00

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ADULT NURSING CARE PLAN

Mr.ANANTHA KRISHNAN.P.N

79/Male/MHI202381290 15/12/2023/iPH202302516





<u> </u>				
Initial Date: 18/12/23	Time: 8:00	Modified Date: Time:		
Reason for Modification:		Diagnosis: 72 Dm / HTN / Seuze	Aothe Stenosis	
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 pol had a smallet	100
Others:	requirements in accordance to his activity level and metabolic needs		E At had a omdies	80.
			N patient that dinner.	POYI
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O₂ ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy	Patient will have normal O₂ saturation Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains within established limits Patient will indicates, either verbally	□ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises □ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order □ Utilise pulse oximetry to check O₂ saturation and pulse rate □ If any O₂ abnormalities detected inform immediately to the concerned physician	- · · · · /	14.55
☐ Others:	or through behavior, feeling comfortable when breathing	□ Place patient with proper body alignment for maximum breathing pattern □ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis □ Note for changes in level of consciousness □ Send sputum for culture and sensitivity based on physician order □ Maintain clear airway by suctioning or encouraging	r Patient 9702	on.
		patient with successful coughing	maintained 987.	W/C
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition	Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output	M pt take over	23
☐ Parenteral Nutrition☐ Others:			E Pt talen floral	
		- Horner Dr. for Grandstate Grianges	N Patient fluid	621

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY ☐ Mebile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Putient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment Consider the need for home assistance (e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Pl mobilized on Beed E P4 MOBILIZED ON BEED Patient Was	Wan and a second
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement Urination Others:	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician Observe voiding accessories as foley's / silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol Check for malena / constipation / urinary retention	M pt Bed pan varidy E Pt Bed pan varidy N CBO (3/2
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE INJURY GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased Intermittent Assisted Dermatitis Pressure injury / blisters site care given Others:	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity		M maintain Normal Skin Integrity E Mouleu (1)80in Integrity Maintained (1) Skin integrity	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2

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 will stey clean groomel. E Pt Will Stay Clear grooms NP+ Stay clean & Well groomed.	8 2 2 Cons
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)	MID Bond & Henl EDD hand D Freth NPI ID hand ©	32/20
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 work comfordation E pt with Comfordation N pt had comparte cheep	Down
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 V/2 monitored EPt V/2 Montany NPt V/3 monitored	Wilson Dona
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 See inspirational words Respond to spiritual needs as they arise Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	M pt psycological E Payholyand Sypport NPSychological Support given	Some on the second of the seco

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Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions Introduce the care giver Encourage the use of call bell Obtain interpreter if needed No negative speaking about the patient's condition or prognosis in the patient's presence		Evaluation		Sign & Initials
COMMUNICAT Verbal Non-verbal Sigh language Others:	CION ,	Patient will communicate effectively with positive feedback				M pt will grown commun E pt w		SU a
SPECIAL INTE Medication Wound care Isolation Ostomy Care Blood / Blood ptransfusion Fluid tapping DVT Managem Others:	products	☐ Jo 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 is and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing b blood products and fluids Monitor DVT score and continue treatment as per doctors order	solation ensure lood or	M pd n E Pt M N Patien green	evalupe.	200 1 2 2 m
	Signature	, ·	Name		Emp. ID		Date	Time
Endorsed by	Jac	1	· ·	TAYAD Eri	000		[7/14/2)	g.cus
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ADULT NURSING CARE PLAN

F Mr.ANANTHA KRISHNAN.P.N

79/Male/MHJ202381290 15/12/2023/JPH202302516

Dr.K.JAISHANKAR





Initial Date: 122	Time: 2,00	Modified Date: Time:		
Reason for Modification:		Diagnosis: TAPM / HTN / SEVERE	CALUPIC ADDIC ST	ENDSYS!
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION Keep NPO Regular Diet Others:	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	M pr- had diet	-M70/32
	activity level and metabolic needs		N Dt had Dondiet	A GIN
OXYGENATION Boom Air Nasal Cannula / High Flow O ₂ Mask BIPAP / CPAP	☐ No other respiratory abnormalities☐ Patient respiratory rate will remains	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O₂ saturation and pulse rate	M FM With slife	Aftaf 0282
☐ Ventilator ☐ Tracheostomy ☐ Others:	within established limits ☐ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing ☐ If any O₂ abnormalities detected inform immediately the concerned physician ☐ Place patient with proper body alignment for maximal breathing pattern	the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis	E Fm Od D litter,	A.
		 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 P+ F-on 0 & literal	8041
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	Pt maintain on Malaned etectodyles.	Armi oest
☐ Parenteral Nutrition ☐ Others:			E Pt Maden confined Restricted	and an
			N Pt Nawtour B fluid	& J.

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
Mobile / Immobile Mobile / Immobile Walk with assistance Physiotherapy	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Putient will use safety measures	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance	M pr mobilized on bed	Strong.
│	to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	(e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	E Pt Mobiblished	Sh.
, i			N Pt on bod mobilized	STI.
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 por men ntain on normal elimination	AProf OUSZ
Others:	and regular elimination patterns	silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	EP+On CBD D2	ST.
	. !	and follow proper protocol Check for malena / constipation / urinary retention	N PT ON CED Prosont	8019
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE	Patient will maintain normal healing status. Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin	primaintain on m normal ship integrifity	ASS
INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased	,		E Mainleuw on P Skin Shape	Se las
☐ Intermittent Assisted : ☐ Dermatitis \ ☐ Pressure injury / blisters site care given ☐ Others:			P+ Maintain (1) Skin integenty	977

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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE Bed-Bath Assist-Bath Self-Care CBD Care (if present) Others:	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs Patient will recognize individual weakness or needs	Encourage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene Consider the patient's need for assistive devices Apply moisturizing solution	M Well groomed. E Wen Stary Clean N Pt closer & woll ground	Mig 2
SAFETY Check ID Hand IV care EJV CENTRAL LINE Side rails Others:	Patient will have no life-threatening situations	Check the identity with ID band before any interaction with the patient Raise side rails Provide proper invasive line care Keep bed locked and low at all time Educate care providers to be the patient Follow restrain policy (if needed)	M Pt ID Dis hourd E Pt Sto P hard N A ID bound Present	Army OTHER
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	N & Provide Confortable	Afond 0182
OBSERVATION ☑ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	Tatient 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- VHALS are Monitoring E Monitor vitalsizes N Wastered VIS charact	A Profession of the Control of the C
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	Psychological Buppost given Ets. Choloper Support N Pt Provide Psychologic Reproductions	A STATE OF THE STA

Patient Specific Problems / Nec		Measurable Goals	==	Nursing Interventions	• •	Evaluation		Sign & Initials
COMMUNICATION ☑ Verbai ☐ Non-verbal		Patient will communic with positive feedback		Introduce the care giver Encourage the use of call bell Obtain interpreter if needed		M Musicing	in good	16.000
Sigh language Others:	ge · · · · · · · ·		□ No negative speaking about the patien or prognosis in the patient's presence	☐ No negative speaking about the patient's condition		cood Communicher	I _	
						N P+ hairta	Ucus nortan	85.61
SPECIAL INTERVENTIONS Medication Wound care Isolation Ostomy Care Blood / Blood products, transfusion Fluid tapping DVT Management		To manage on time		Double check for high alert medication Doserve and report any medication rea Provide proper measures of wound car Follow hospital polices and protocols of	е	M Daning (Ols ples of	followed art-	Wigan
		1		and explain to the patient / family Check for cross matching and typing, to ensure compatibility Practice strict asepsis while transfusing blood or blood products and fluids Monitor DVT score and continue treatment as per doctors order		E Median	naspen nart.	
Others:	Sin.					la regio Pener 19 M		\$ o
	Signature	,	Name		Emp. ID		Date	Time
Endorsed by	Jay			JAYADEN,	00	0	Whiles	9.4
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ADULT NURSING CARE PLAN

Mr.ANANTHA KRISHNAN.P.N 79/Male/MHI202381290 15/12/2023/IPH202302516 Dr.K.JAISHANKAR



DF.R.JAISHANKAR

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Initial Date: $19/\omega/3$	Time: <i>& i D ⊙</i> .	Modified Date: Time:					
Reason for Modification:		Diagnosis: 78 DM/ 4770/ SEVERE CALCUTY ADRIVE STENDER ? UTI CCF					
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
NUTRITION Keep NPO Resolved Birth	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 & Pton DN glat	Axe.			
Regular Diet Others:	requirements in accordance to his activity level and metabolic needs	Hecord amount of food consumed	E Pot on Domailiet	aba			
	; , ,		n pt had pm diel	1012L			
OXYGENATION Room Air Nassel Coppula / High Flow O	☐ Patient will have normal O₂ saturation☐ Patient ABG levels will return to and remain within normal limits	Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises Provide well-ventilated environment / respiratory	M PHON AMQUEL	0.2			
│ Nasal Cannula / High Flow O₂ │ Mask ⋅ │ BiPAP / CPAP	☐ No other respiratory abnormalities☐ Patient respiratory rate will remains	medications / Oxygen as per doctors order Utilise pulse oximetry to check O ₂ saturation and pulse rate	m Pron Amales) onto w	3000			
☐ Ventilator ☐ Tracheostomy ☐ Others:	within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☐ If any O₂ abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central vehouse in level of appreciations of the control of the property of the control of th	E Pt 8002991.				
		□ 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	pt is on Room Air	OLL OLL			
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 Spton Tlo Chart majorianed	Dov			
☐ Enteral Nutrition ☐ 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 P+T/O chas)	De j			
		j	N I/O chalit	621			

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease P-tient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment Consider the need for home assistance (e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Spton 4hrly Nobel wood E Pt Wolf Mobilized N Pt well Mobilized	80° S S S S S S S S S S S S S S S S S S S
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement Urination Others:	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M Spron CBDD -D3 E Pt (Patern Pt on CBD D P3 N Pt seef voided	() () () () () () () () () ()
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased Intermittent Assisted Dermatitis Pressure injury / blisters site care given Others:	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	* pton Maintain M (B) skon unilogity E pt P Bors Inguity maintain normal N slain integrity	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2

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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE Bed-Bath Assist-Bath Self-Care CBD Care (if present) Others:	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs Patient will recognize individual weakness or needs	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	M Dean guell geroom E PA Well Grieno N PH well groomed	130 PS 413
SAFETY Check ID Hand IV care EJV CENTRAL LINE Side rails Others:	Patient will have no life-threatening structions	Check the identity with ID band before any interaction with the patient Raise side rails Provide proper invasive line care Keep bed locked and low at all time Educate care providers to be the patient Follow restrain policy (if needed)	M & PHONCHOUK ID bound (1) E Pt Db brigh house N ID band onesent	00 00 00 00 00 00 00 00 00 00 00 00 00
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	
OBSERVATION Vital Signs GCS Blood Sugar Others:	Patient will have normal range of vital parameters		m sptonvl8 chelled 9 records E Pt v/s checked A sprosted	JAN AND STA
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 	E N	_

Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions	·	Evaluation		Sign & Initials
COMMUNICAT Verbal Non-verbal Sigh language Others:		☐ Patient will communic with positive feedback		☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's or prognosis in the patient's presence	condition	N py good	mm aton	Ai
SPECIAL INTE Medication Wound care Isolation Ostomy Care Blood / Blood p transfusion Fluid tapping DVT Manageme	, products	To manage on time		Double check for high alert medication Observe and report any medication react Provide proper measures of wound care Follow hospital polices and protocols of i and explain to the patient / family Check for cross matching and typing, to compatibility 7. 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 gilver a E flell N medic	spendon Spendong Catton Spendon Contion Siver Spendon Siver Spendon Siver Survey Chart	75
	Signature		Name		Emp. ID	· · · · · · · · · · · · · · · · · · ·	Date	Time
Endorsed by	•	Noon		8- Nalini	00	84	18/12/23	14:00

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ADULT NURSING CARE PLAN

Mr.Anantha Krishnan.P.N

| 79/Mule/MH1202381290

15/12/2023/IPH202302516

L Dr.K.JAISHANKAR



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	Initial Date: 9 2 2-3	Time: & Oo	Modified Date: Time:		
	Reason for Modification:		Diagnosis: ser calcific aoutic	Stenosis	
	Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
	NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	M pt had Nomed E Pt had Normal Alel N pt had O diet	Jodes ALL
	OXYGENATION Room Air Nasal Cannula / High Flow O₂ Mask BiPAP / CPAP Ventilator Tracheostomy Others:	Patient will have normal O₂ saturation Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	 Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order Utilise pulse oximetry to check O₂ saturation and pulse rate If any O₂ abnormalities detected inform immediately to the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis Note for changes in level of consciousness Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging patient with successful coughing 	M pt on foom air E 3PO2-95% N pt is on Room N dig	Sec 20088
	FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition Parenteral Nutrition Others:	Patient will have balanced fluid and electrolytes balance	□ Enhance fluid intake unless restricted □ Check IV sites and assess if there is any complication □ Provide tube feedings □ Monitor intake and output □ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses □ Monitor for possible sources of fluid loss □ Monitor BP for orthostatic changes	M Pt Dlo Chart Moniteres. E Alo chart Moniteres. No chart No chart No chart	Jen Africas Air of 22

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Putient will use safety measures	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance	M pt mobilized well.	Jey
Coners.	to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	(e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	EPt well mobilized	£.C 0207
			N Pd well mobilized	A STOL
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,	□ Encourage early ambulation □ Report any abnormalities to physician □ Observe voiding accessories as foley's / silicone catheter □ Check placement before feeding □ Aspirate NG tube, check colour / consistenct	M Pt in O couth.	In
Others:	control of bowel incontinence, and regular elimination patterns		and regular elimination patterns silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	EPt is U-cath
		and follow proper protocol Check for malena / constipation / urinary retention	n v-cath	Ar ONL
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE	Patient will maintain normal healing status Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin	M pt Maintain normal slain integrity.	<u>J.s.</u>
INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased			Pt maintain Enormal skin integrity	2°
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N -	

Dationt Consider				- · ·
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath	Patient will stay clean and well-groomed Patient will demonstrate lifestyle	Encourage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene	M Pt groomedele.	Ses
☐ Self-Care ☐ CBD Care (if present) ☐ Others:	changes to meet self-care needs Patient will recognize individual weakness or needs	☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution	EPt well groomed	D(5007
			NP+ well groomed	An'
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 Pt 20 band Cheekel	Jus_
CENTRAL LINE Side rails Others:	,	☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient ☐ Follow restrain policy (if panded)	EPA ID Band @	DC Bart
	·	☐ Follow restrain policy (if needed)	N Pt FD band (1)	Sil.
COMFORT AND SLEEP Pain Control	Patient will have comfortable sleep Patient will verbalize / or through	☐ Provide clean calm and restful environment☐ Provide privacy at all time	м —	
☐ Sleep Patterns ☐ Others:	behavior about pain relief and adequate sleep	Monitor pain scale / sleep pattern Provide pharmacological and non-pharmacological therapy	E	
	i		N — '	
OBSERVATION Vital Signs Good Sugar	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality	M Vitals are checked.	Sm
☐ 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 VIS Checked & recorded	DC 0207
			N PA VIO checked El	Ai 0122
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	

Patient Specific Problems / Nec		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
©ÓMMUNICAT ☐ Verbal ☐ Non-verbal ☐ Sigh language ☐ Others:	ION	Patient will communicate with positive feedback	effectively	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's or prognosis in the patient's presence	s condition		menication coele	Je
SPECIAL INTEL Medication Wound care Isolation Ostomy Care Blood / Blood p transfusion Fluid tapping DVT Manageme Others:	roducts	☐ To manage on time		Double check for high alert medication Observe and report any medication read Provide proper measures of wound care Follow hospital polices and protocols of and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing to blood products and fluids Monitor DVT score and continue treatment as per doctors order	isolation ensure blood or	M pt den are & E Pt alue are N due drag	e deugs e drugs given	DO SOF
	Signature	. N	Name		Emp. ID	•	Date	Time
Endorsed by		Nas	2	· Nalini		6024	19/12/23	18:0

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ADULT NURSING CARE PLAN

MI.AGANTHA KRISHNAN.P.N

79/Male/MHI202381290 15/12/2023/IPH202302516

Dr.K.Jaishankar



Initial Date 20 12 22 Time! 6.00 **Modified Date:** Time: Diagnosis: Severe calcific day aboutic stenosis Reason for Modification: **Patient Specific** Sian & **Nursing Interventions Evaluation** Measurable Goals Problems / Needs Initials NUTRITION Patient will have adequate nutrition Provide Prescribed diet on time Jan ☐ Keep NPO with no nausea and vomiting ☐ Encourage patient to consume the served meal ☐ Regular Diet ☐ Patient will consume daily nutritional ☐ Record amount of food consumed Others: requirements in accordance to his activity level and metabolic needs Ν OXYGENATION ☐ Patient will have normal O₂ saturation Encourage chest physio / deep breathing and Patient ABG levels will return to and coughing exercise / Spirometry exercises ☐ Room Air Provide well-ventilated environment / respiratory ☐ Nasal Cannula / High Flow O₂ remain within normal limits ☐ Mask ☐ No other respiratory abnormalities medications / Oxygen as per doctors order ☐ BIPAP / CPAP ☐ Patient respiratory rate will remains Utilise pulse oximetry to check O, saturation and pulse rate ☐ If any O₂ abnormalities detected inform immediately to ☐ Ventilator within established limits ☐ Tracheostomy ☐ Patient will indicates, either verbally the concerned physician ☐ Others: Place patient with proper body alignment for maximum or through behavior, feeling 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 Ν Maintain clear airway by suctioning or encouraging patient with successful coughing , FLUID & ELECTROLYTES ☐ _Enhance fluid intake unless restricted Patient will have balanced fluid and 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 Ν

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)	M P4 Mobilized well.	Ja
3-	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	and.
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement Urination Others:	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hernetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M pt Normal elemination father E perfora 500	Jan DON DON
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 Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	M pt praintain Normal skin Integrity.	Ser

HYGIENE Bed-Bath Patient will stay clean and well-groomed Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs Patient will recognize individual weakness or needs Patient will recognize individual weakness or needs Patient will have no life-threatening Check ID Hand Voare EJV CENTRAL LINE Side rails Others: Side rails Others: Patient will have no life-threatening Follow restrain policy (if needed) Follow restrain policy (if needed) N PATIENT will have no life-threatening M PATIP Deard Follow restrain policy (if needed) N PATIP Check the identity with ID band before any interaction with the patient Patient will have no life-threatening Provide proper invasive line care E SD for of N PATIP Patient will have no life-threatening Provide proper invasive line care E SD for of N PATIP Patient will have no life-threatening Patient with the patient Patient with the patient Patient with ID band before any interaction with the patient Patient with the patient Patient with ID band before any interaction with the patient Patient with ID band before any interaction with the patient Patient with ID band before any interaction with the patient Patient with ID band before any interaction with the patient Patient with ID band before any interaction with the patient Patient with ID band before any interaction with the patient Patient with ID band before any interaction with the patient Patient with ID band before any interaction with the patient Patient with ID band before any interaction with the patient Patient with ID band before any interaction with the patient Patient with ID band before any interaction with the patient Patient with ID band before any interaction with the patient Patient with ID band before any interaction with the patient Patient with ID band before any interaction with the patient Patient with ID band before any interaction with ID band before an	Measurable Goals	Nursing Interventions		ign & nitials
SAFETY Check ID Hand Definition will have no life-threatening situations Check the identity with ID band before any interaction with the patient Raise side rails Check the identity with ID band before any interaction with the patient Raise side rails Check the identity with ID band before any interaction with the patient Raise side rails Check the identity with ID band before any interaction with the patient Raise side rails Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with the patient Check the identity with ID band before any interaction with ID band before any interaction with ID band before any interaction with ID band before any interaction with ID band before any interaction with ID band before any interaction with ID band before any inte	well-groomed Patient will demonstrate lifest changes to meet self-care new present) Patient will recognize individu	☐ Change patient's gown daily☐ Encourage hand hygiene☐ Consider the patient's need for assistive devices	M pt growinger -	
Check ID Hand		<u> </u>	N .	
☐ Side rails ☐ Others: ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed) ☐ Educate care providers to be the patient ☐ Follow restrain policy (if needed)	situations	interaction with the patient Raise side rails	Cheelod -	-t
		☐ Keep bed locked and low at all time☐ Educate care providers to be the patient	E SD hard &	214/
			N	
COMFORT AND SLEEP Patient will have comfortable sleep Pain Control Sleep Patterns Patient will verbalize / or through behavior about pain relief and Provide clean calm and restful environment Provide clean calm and restful environment Provide privacy at all time M M Monitor pain scale / sleep pattern	Patient will verbalize / or thro	Provide privacy at all time	M	-
☐ Others: adequate sleep ☐ Provide pharmacological and non-pharmacological therapy ☐ E		Provide pharmacological and		
N	<u> </u>		N	
OBSERVATION Vital Signs Of vital parameters OBSERVATION Inform doctor if there is any abnormality OBSERVATION Inform doctor if there is any abnormality		☐ Monitor vital signs on ordered time☐ Assess physically for any abnormality	M Pt vitale are J-	er_
☐ Others: ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per dootors order ☐ Control of the contro		☐ Monitor GCS of patient☐ Determine and treat the underlying cause of altered L	E STAND	Sept
N			N	
PSYCHOLOGICAL / Patient will achieve spiritual needs SPIRITUAL SUPPORT Patient will be able to control his Spiritual Needs Feeling to ward his illness Feeling to ward his illness Feeling to provide the patient to pray Use inspirational words Respond to spiritual needs as they arise	feeling toward his illness	☐ Use inspirational words☐ Respond to spiritual needs as they arise	M	
☐ Beliefs / Values / Customs ☐ Patient will maintain normal psychological pattern ☐ Evaluate spiritual needs ☐ Identify Stressors ☐ Others: ☐ Provide empathy and reassurance ☐ Evaluate spiritual needs ☐ Encourage verbalization of feelings / therapeutic touch ☐ Provide empathy and reassurance ☐ Evaluate spiritual needs ☐ Provide empathy and reassurance ☐ Evaluate spiritual needs	oying Pattern psychological pattern	Encourage verbalization of feelings / therapeutic touc	E	
N N			N	

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Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATURET Sigh language	TION	Patient will communic with positive feedback		☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's or prognosis in the patient's presence	s condition	M A COMM	nunication alli-	Jan Jan
SPECIAL INTE Medication Wound care Isolation Ostomy Care Blood / Blood / transfusion Fluid tapping DVT Managem Others:	products	To manage on time		Double check for high alert medication Observe and report any medication react Provide proper measures of wound care Follow hospital polices and protocols of i and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing belood products and fluids Monitor DVT score and continue treatments as per doctors order	isolation ensure plood or	M et di E qi	re dengs ven.	Sees
	Signature		Name		Emp. ID		Date	Time
Endorsed by		Noo	<u> </u>	. Nalini	00	04	20/12/23	16:00
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79/Male/MHI202381290

15/12/2023/IPH202302516

Dr.K.JAISHANKAR





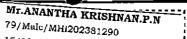
Every heart beat counts

Date:

	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Time		12/	22 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	A
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Molst Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Molst Skin is usually dry, linen only requires changing at routine intervals		€,	3
ACTIVITY degree of physical activity	1. Bedfast Confired 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. Stight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance		3	3
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or 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		7	3
FRICTION	Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair			3	3
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair		TOTAL SCORE		17	/#
	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:			dis
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:		Br	Too







15/12/2023/IPH202302516





Date: 6 12 23

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK Time:	m	12 2-	2
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4-No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort		4	A
MOISTURE degree to which skin is exposed to moisture	1.Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Molst Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals		3	3
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	l 1 -	1	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	akes frequent through slight changes in Makes major and frequent		3	3
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	3	3	3
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem Moves in bed and in chair independently and has sufficient must rength to lift up completely during move. Maintains good position in or chair		3	3	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	LI LI	17	17 80 804
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	of Staff Nurse: Initial & Emp. No. of Sr. Staff Nurse:	100	Te .	2		





Mr.ANANTHA KRISHNAN.P.N

79/Male/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR



MHI/NUR/2022/045



	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	V DIOIZ	Date: /	# 1	2	23 V
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, bet 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 Notmpairment Responds to vert commands. Has no sens deficit which would li ability to feel or voice pair discomfort	ory mit	4	4	Ц
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 or requires changing at rou intervals		3	3	3
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 le twice a day and inside re at least once every two he during waking hours	oom	t	1	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 with assistance		3	3	ર
NUTRITION usual food intake pattern	Never 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 m Never refuses a me Usually eats a total of a more servings of meat diary products. Occasion eats between meals. D not require supplemental	eal. 4 or and hally oes	3	3	3
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem Moves in bed and in chair independently strength to lift up completely during move. Nor chair		cle ,	3 5	3	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 SCO Initial & Emp. 1 of Staff Nur	No/(5 N	5	15 80
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. I of Sr. Staff Nur	Vo.		7	7000





MI.ANANTHA KRISHNAN.P.N

79/Male/MH1202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Time:		12_	22
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		9	A
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Molst Skin is often, but not always moist. Linen must be changed at least once a shift	Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	3	3	3
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours		3	3
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, Skight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	3	3	3
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation		3	3
FRICTION	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	3	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 Initial & Emp. No. of Staff Nurse:	19 Dis)	19 2601	19
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:	Z	124	Neg





Pe Mr. ANANTHA KRISHNAN.P.N Na 79/Malc/MHI202381290 UH 15/12/2023/IPH202302516 DOI DI.K.JAISHANKAR
DOI
Con:

MHI/NUR/2022/045 Nedway Heart Institute Every heart beat counts

(A Unit of United Allia	ance Healthcare Pvt Ltd)	·	Gon; Hannan	<u>i</u> '	verg na :Date	$\overline{}$	12	
	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISK	Time:	111	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	Responds to commands. Has no deficit which wor ability to feel or voic discomfort	sensory uld limit	A	4	4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Parely Moist Skin is usually dry, requires changing intervals		A	4	4
ACTIVITY degree of physical activity	Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non- existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	Walks Frequenti Walks outside roon twice a day and ins at least once every t during waking hour	n at least ide room wo hours	4	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 changes in position assistance		4	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	A Excellent Eats most of eve Never refuses: Usually eats a tota more servings of r diary products. Occ eats between mea	a meal. I of 4 or neat and asionally Is. Does	A	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	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 independently strength to lift up completely during move. Nor chair	faintains good position	on in bed	3 23	<u>3</u> 3	
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down			f Nurse: -			Ai
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; F	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & E of Sr. Staf		24	24	24







MHI/NUR/2022/045 Medway

Date:	30	12	23
Time;	M	E	2

	BRADEN S	CALE FOR PREDICTIN	NG PRESSURE INJUR	Y RIS		ime;		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	command deficit w	nds to verb ds. Has no senso phich would lin eel orvoice pain	ory mit	4	St.	
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		Moist ually dry, linen o changing at rout		4	JA	
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	Walks ou twice a da at least or	Frequently tside room at le ay and inside ro- nce every two ho aking hours	om	4	de	
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		najor and frequi in position with	nout	4	df	
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	Never r Usually e more ser diary prod eats betv	ent st of every me efuses a me eats a total of 4 vings of meat a ducts. Occasiona veen meals. Do esupplementati	eal. For and ally oes	4	46	
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 independently strength to lift up completely during move. N				3	3	
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair			TOTAL SCOP	RE	2 <u>.</u> S	23	
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down			Initial & Emp. N of Staff Nurs		The C	S.	
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; F	ligh Risk: 12 - 10; Severe Risk: 9 - 6		Initial & Emp. Nors		New		



Mr.ANANTHA KRISHNAN.P.N

79/Male/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR



MH/BS/IP/2022/027

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



Mr.Anantha krishnan.p.n

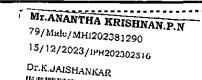
79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR



MH/BS/IP/2022/027

	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Time	::]_[:: M	19_	9.3
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 verba commands. Has no sensor deficit which would limi ability to feel or voice pain o discomfort	/ t	3	3
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 onl requires changing at routin- intervals		3	3
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 hour during waking hours	ור	3	3.
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequer changes in position withou assistance		2	2
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every mea Never refuses a meal Usually eats a total of 4 o more servings of meat and diary products. Occasionallieats between meals. Doe not require supplementation	r d z z	2	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 assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently strength to lift up completely during move. No or chair		3 15	3 4 1	3 1 5 1 45 1 43 2 43 1 43
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; F	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:		6.4	किनी क्षर



MH/BS/IP/2022/027

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

	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Time	14	12	23
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verba commands. Has no sensory deficit which would limi ability to feel or voice pain o discomfort	/ t _	3	3
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 a day	4. Rarely Moist Skin is usually dry, linen onle requires changing at routing intervals	3	3	3
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non- existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at leas twice a day and inside room at least once every two hours during waking hours	٦ ٦	3	3
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequen changes in position withou assistance		2	2
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal Never refuses a meal Usually eats a total of 4 o more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	2	2	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 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 independenti strength to lift up completely during move. N or chair		15	3 5 8 1	3
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. of Sr. Staff Nurse:	Caro	Co Vo	100 S







Mr.Anantha krishnan.p.n

79/Male/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR

MHI/NUR/2022/052



Date & Time	Pạin 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.
15/12/3 12.15	0/10	Nopain					Jay oon
[3.00	%io	No pain					Joy ook
14.00	%	Nopain		<u> </u>			Joy on
12:00	no	Nopain				A Comment	Jay of
t600	‰	Nopous		<u>-</u>			Jay 00
700	no	Nopan	_			an a	Jan of
(8.00	%0	Mo bais		-	<u></u>	A.	Joy on
1900	No	No pain	_	<u></u>			Josef ora
90·00	oflo	Nofrain	-			for our	Joj sa

										
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.
15/12/23			;			·		1, .		
21100	oho		lo pain				<u>-</u>		02414	Joy 00
24·00	oho		No pain					102 . 132 (162 173	D. H.H	Jay 00
		. "	10 Pan				•		W2 hr	Joylor
12/22	0/8	<u> </u>	No Pan	_				j -	OPA Y	Joy of
	ı.				P/	AIN SCALES				* 7
(28 wee	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		<u> </u>		
(38 we	CRIES eks - 2 m	onths)					re of 10 is possible. If the CRIES score ted for a score of 6 or higher.	is > 4,	1	,
	LACC Sca onths - 7 y		0: Relaxed & comfortable	e, 1-3: Mild d	iscomfort, 4-6: Mod	erate discomfort, 7-10: Severe	e discomfort / pain / both		,	
Palt	g-Baker FA n Rating S ars - 12 ye	cale	O 2 No Hurts Hurts Little Bit	(©) 4 Hurts Little Mors	6 Hurts Even More	8 10 Hurts Whole Lot Worst	Numerical Rating Scale (a	6	7 8	9 10
Observ	ical care i ation Tool ator / com	(CPOT)	COMPLIANCE WITH VE	Absence of m NTILATION (I ubated patler Relaxed, 1 - Te	novements or normal ntubated patlents): nts): 0 - Talking on no ense, Rigid, 2 - Very To	position, 1 - Protection, 2 - Res 0 - Tolerating Ventilator or Move ormal tone or no sound, 1 - Sigl ense, Rigid	tlessness / Agitation ement , 1 - Coughing but tolerating, 2 - F ning, Moaning, 2 - Crying out, sobbing	ighting v	entilator (or)	
	harmacol tervention		Cutaneous Stimulation a Thermal Therapies (no lo	ind massage onger than 15	: E - Positioning; F - F to 20 minutes): G - C	C - Music; D - Physical and men tubbing / Massage the skin old application; H - Hot applica terferntial therapy Psycho-s		l Couņse	ling; L - Family	counseling
Pharma	cological i	nterventio	ns as per doctor's prescrip	tion			<u> </u>	•		





MT.ANANTHA KRISHNAN.P.N 79/Mulc/MHI202381290

15/12/2023/1РН202302516

Dr.K.JAISHANKAR



MHI/NUR/2022/052



PAII	N RI	E-ASSESSMENT	& MC	NITORING	CHART		Every heart b	eat 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.
12/23	0/0	No Parin		-	<u></u>		024114	-Jayoon
2-00	0/6	No Pain			(©≥ny	Jou José
3.90	9/60	no Pain	1	ر	(6244	Jan os
h.00	0/60	No Pain			(DEACH	- Jay Cook
5-00	%	No Pain	,	<u> </u>	7		22464	Joe Jose
6.00	%	No Pain	,				674A	Joe Good
4.00	960	No Pain					Ozno	Joygon
රිුලට	0/10	No poen					280	Jay 00
9.00	0/0	No pain						Joy ool

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.
10.00	2/6	ρ_0	pain		-		Wed -	Jan on
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<u> </u>	<u> </u>	_	-		P/	AIN SCALES		<u> </u>
(28 week	PIPPS ks to <u><</u> 38	l weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provi >12 = Moderate to sever	de comfort me		on		
(38 we	CRIES eks - 2 m	onths)				of gestation. A maximal score of 10 is possible, if the CRIES scor	re is > 4,	
	LACC Sca		0: Relaxed & comfortable	e, 1-3: Mild d	lscomfort, 4-6: Mode	erate discomfort, 7-10: Severe discomfort / pain / both		
Pain	g-Baker F <i>i</i> n Rating S ars - 12 y	cale	O 2 No Hurts Hurts Little Bit	4 Hurts Little More	6 Hurts Even More	Numerical Rating Scale Numerical Rating Scale 10 1 1 2 3 4 10 1 2 3 4 10 10 10 10 10 10 10 10 10 10 10 10 10	 	9 10
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	harmacol tervention		Cutaneous Stimulation : Thermal Theraples (no le	and massage onger than 15	: E - Positioning; F - F to 20 minutes): G - C	- 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 - Individu	al Counseling; L - Family co	ounseling
Pharmac	cological i	ntervention	ns as per doctor's prescrip	otion				







Pr Mr.ANANTHA KRISHNAN.P.N
N 79/Malc/MHI202381290
U 15/12/2023/IPH202302516
C Dr.K.JAISHANKAR

Heart Institute

MHI/NUR/2022/052

Every heart beat counts

PAIN RE-ASSESSMENT & MONITORING CHART

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	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions		Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
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Time Score Colin acry, snarp, stabling, snooting, burning, referred / radiant pain) Duration						`~			ì -						
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Pharmacological interventions as per doctor's prescription	Pharmac	ological	Interventio	ns as per d	loctor's prescrip	otion					,				







Mr.ANANTHA KRISHNAN.P.N

79/Male/MHI202381290

15/12/2023/IPH202302516

Dr.K.JAISHANKAR

MHI/NUR/2022/052



PAII	N ₁ RI	E-ASSESSMENT	& MC	NITORING	CHART	Every	heart beat counts
l	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions		Senior Staff Initial & Emp. No.
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Date & Time	Pain Score	P (dull, achy, burning	rain Character , sharp, stabbing, shooting , referred / radiant pain)	Duration	Location / Site		Interventions		Staff Initial & Emp. No.								
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(38 we	CRIES eeks - 2 mo	onths)					score of 10 is possible. If the CRI licated for a score of 6 or higher.										
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None	harmacol	ngleal				- Music; D - Physical and r ubbing / Massage the skin			_								

* ^{,t}







Mr.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR



MHI/NUR/2022/052



	PAII	N RI	E-ASSESSMENT	& MC	NITORING	CHART	Every heart be	at counts
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Pain	-Baker F/ Rating S ars - 12 y	cale		((%)) 0 est	2 Hurts Little Bit	Hurts	4 s Little	6 Hurts Even More	(8 10 Hurts Hurts Worst	O None	imei	rical 2	;	ing §	4	e (ag	6	7	8 Sev	9	10
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	harmaco! tervention		Cut The	aneo rmal	ous Stimulation Theraples (no	and mass	sage in 15	: E - Positioning to 20 minutes):	; F - Ru G - Col	Music; D - Physical and men bbing / Massage the skin d application; H - Hot applica rferntial therapy Psycho-s	tion; I - Sh	ortwa	ave dia	itherr elling	ny p: K - I	Individ	dual C	ounse	ling; L -	Family	couns	eling
Pharmac	ological I	nterventlo	ıs as	per d	loctor's prescri	ption																







P Mr.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516

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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.
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Time Score (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain) Duration Location / Site Interventions Staff Initial & Emp. No. Pain														
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PAIN SCALES PIPPS (28 weeks to ≤ 38 weeks) CRIES The CRIES scale (28 months) FLACC Scate (2 months - 7 years) O: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both Wong-Baker FACES Pain Rating Scale (7 years - 12 years) Critical care Pain Critical care Pain Cherry and Company Critical care Pain Cherry and Company Critical care Pain Cherry and Company Critical care Pain Cherry and Company Critical care Pain Cherry and Company Critical care Pain Cherry and Company Company Critical care Pain Cherry and Cherry Critical care Pain Cherry and Cherry Critical care Pain Cherry and Cherry Critical care Pain Critical care Pain Cherry and Cherry Critical care Pain Non-pharmacological Interventions Non-pharmacological Interventions Non-pharmacological Interventions Non-pharmacological Interventi	38 ∕0°°			No	pain	-	-		·	A STI	Nac			
PIPPS (28 weeks to ≤ 38 weeks) (28 weeks to ≤ 38 weeks) (28 weeks to ≤ 38 weeks) (28 weeks to ≤ 38 weeks) (29 weeks to ≤ 38 weeks) (20 weeks to ≤ 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further plants to the control of the top of th	19/12/23 3.00	0/10	ı	Vo	pair	OLL 2	Nuon							
PIPPS (28 weeks to ≤ 38 weeks) CRIES (38 weeks - 2 months) The CRIES scale is used for Infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher. FLACC Scale (2 months - 7 years) O: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both Wong-Baker FACES Pain Rating Scale (7 years - 12 years) 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 - Tolerating Ventilator or Movement, 1 - Coughing, Moaning, 2 - Crying out, sobbing University of the pain	1.00	0/10	1	00	oun	A SIL	Nag							
7-12 = Midd pain - Provide comfort measures 7-12 = Moderate to severe pain - Pharmocological intervention 7-12 = Moderate to severe pain - Pharmocological intervention 7-12 = Moderate to severe pain - Pharmocological intervention 7-12 = Moderate to severe pain - Pharmocological intervention 7-12 = Moderate to severe pain - Pharmocological intervention 7-12 = Moderate to severe pain - Pharmocological intervention 7-12 = Moderate to severe pain - Pharmocological intervention 7-13 = Moderate to severe pain - Pharmocological intervention 7-13 = Moderate to severe pain - Pharmocological intervention 7-13 = Moderate to severe pain - Pharmocological intervention 7-13 = Moderate to severe pain - Pharmocological intervention 7-13 = Moderate to severe pain - Pharmocological intervention 7-13 = Moderate to severe pain - Pharmocological intervention 7-13 = Moderate to severe pain - Pharmocological intervention 7-13 = Moderate to severe pain - Pharmocological intervention 7-13 = Moderate to severe pain - Pharmocological intervention 7-13 = Moderate tall intervention 7-						<u> </u>		AIN SCALES	<u> </u>					
Critical care Pain Observation Tool (CPOT) (ventilator / comatose) Critical care Pain Observation Tool (CPOT) (ventilator / comatose) Complete of the co	(28 weel		weeks)	7 - 12 =	= Mild pain - Provid	de comfort me		ion	<u>-</u> -	· · · · · · · · · · · · · · · · · · ·				
Wong-Baker FACES Pain Rating Scale (7 years - 12 years) Critical care Pain Observation Tool (CPOT) (ventilator / comatose) Non-pharmacological Interventions O: Relaxed & comfortable, 1-3: Milid discomfort, 4-5: Moderate discomfort, 7-10: Sever	(38 we		onths)							ore is > 4,	, , , , , , , , , , , , , , , , , , ,			
Wong-Baker FACES Paln Rating Scale (7 years - 12 years) O 2 4 6 8 10 No No Hurts Hurts Hurts Hurts Hurts Hurts Hurts Hurts Whole Lot Worst Worst Worst Observation Tool (CPOT) (ventilator / comatose) FACILIZATION (non-Intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing MUSCLE TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid TOTAL SCORE: 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain Distraction: A - Relexation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers: Cutaneous Stimulation and massage: E - Positioning; F - Rubbing / Massage the skin Thermal Theraples (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy Transcutaneous electrical nerve stimulation (TENS): J - Interferntial therapy Psycho-social therapy/counselling: K - Individual Counseling; L - Family counseling				0: Rela	xed & comfortabl	e, 1-3: Mild d	iscomfort, 4-6: Mod	erate discomfort, 7-10: Sever	e discomfort / pain / both		_			
Critical care Pain Observation Tool (CPOT) (ventilator / comatose) Non-pharmacological interventions BODY MOVEMENTS: 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation COMPLIANCE WITH VENTILATION (Intubated patients): 0 - Tolerating Ventilator or Movement, 1 - Coughing but tolerating, 2 - Fighting ventilator (or) VOCALIZATION (non-Intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing MUSCLE TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid TOTAL SCORE: 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain Distraction: A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers: Cutaneous Stimulation and massage: E - Positioning; F - Rubbing / Massage the skin Thermal Therapies (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy Transcutaneous electrical nerve stimulation (TENS): J - Interferential therapy Psycho-social therapy/counselling: K - Individual Counseling; L - Family counseling	Pain	Rating S	cale	0	2 Hurts	4 Hurts Little	6 Hurts	8 10	0 1 2 3 4	5 6 7 8	9 10			
Non-pharmacological Interventions Distraction: A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers Cutaneous Stimulation and massage: E - Positioning; F - Rubbing / Massage the skin Thermal Therapies (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy Transcutaneous electrical nerve stimulation (TENS): J - Intervential therapy Psycho-social therapy/counselling: K - Individual Counseling; L - Family counseling	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													
Pharmacological Interventions as per doctor's prescription	Non-p	Non-pharmacological Interventions Distraction: A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers Cutaneous Stimulation and massage: E - Positioning; F - Rubbing / Massage the skin Thermal Therapies (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy												
	Pharmac	ological	nterventio	ns as per	doctor's prescrip	otion								







Mr.ANANTHA KRISHNAN.P.N

79/Mulc/MHI202381290 15/12/2023/IPH202302516 .

Dr.K.JAISHANKAR



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.
19/12/33	0/10	No Pair	<u>. </u>	1		Je	Nas
1830	0)0	No pain		_		D(0207	Naas
B-30	0)10	No pair				P(0207	Nas-
20,30	ollo	No pais	-			A1 022	Nao- 024
80/13/2	0/10	No pain		<u></u>		Ai 0211	Nac.
430	10 Ju	NO pain				Añ.	Nas
\$,00	alo	No Pain	-			<u>Lan</u>	Naa-
[0,00	0/10	No pain	-			Jen 020	Nas Ork
لفصلكا	elv	No by	_	1		SIN	vee voog

Date & Time	Pain Score	(dull, achy,	ain Cha sharp, sta , referred /	racter bbing, shooting, radiant pain)	Duration	Location / Site				aff Initi Emp. N	31 li	nior Staf nitial & mp. No.				
18.00	%		ola	pción	-	-		-				<u>-</u>		£o	4 01	DBY
	1 1											,				<u>.</u>
	,															y.
					<u></u>	P/	IN SCALES			- 1					1	
(28 wee	PIPPS ks to <u><</u> 38	weeks)	7 - 12 = >12 = 1		ide comfort me re pain - Phare	nocological intervention								_	- 1,	
(38 we	CRIES eks - 2 m	onths)					of gestation. A maximal so esic administration is indic					core is :	> 4,			
	ACC Sca onths - 7 y		0: Relax	ed & comfortab	le, 1-3: Mild d	Iscomfort, 4-6: Mode	rate discomfort, 7-10: Seve	re discomfort /	pain / bo	th					_	
l Wong	g-Baker F <i>i</i> 1 Rating S ars - 12 y	cale	(%) 0 %	2 Nurts	(OO) Hurts Little More	6 Hurts Even More	8 10 Hurts Hurts Hole Lot Worst	0 1	erical Ra	ating 3	+ 4 ↑	e (age	more	 	2 year 9	rs)
			Hurt	Little 8ft	11.014	Ever, Niero		None	Mild		, and	nogerate				
(7 ye	ical care i ation Tool ator / com	(CPOT)	FACIAL BODY N COMPL VOCALI MUSCL	EXPRESSION: MOVEMENTS: 0 IANCE WITH VE ZATION (non-in	0 - Relaxed, Ne - Absence of m ENTILATION (I tubated patler Relaxed, 1 - Te	eutral, 1 - Tense, 2 - G novements or normal ntubated patients): 0	position, 1 - Protection, 2 - Re - Tolerating Ventilator or Mov rmal tone or no sound, 1 - Si nse, Rigid	estlessness / Agi	itation ghing but		ting, 2	· ? - Fightii	ng venti	ator (or)		





MT.ANANTHA KRISHNAN.P.N

79/Male/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





DVT RISK ASSESSMENT

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

	Date	15/12/2	165 12	ral ale	18/10/23	19/2/23	2012 2	<u> </u>
	Time	1200	A -00	$\overline{}$	P100		6000	
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	p	0	0	0	Ø	0	
2	Bedridden recently >3 days or major surgery within four weeks	@ 	0		0	10	0	
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	Ø	0	0	0	Ø	0	
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	O	0	(i)	0	0	O	
5	Entire leg swollen (Assess for both legs)	P	O	(0	0	Φ	0	
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0		0	0	0	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	6	D	(0	0	6	0	
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	0	0	6	0	
9	Previously documented DVT (Assess for both legs)	0	0		0	0	Ø	
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.	D	0	, @	0	O	٥	
	FINAL SCORE	מ	0	0	0	Ø	0	
Low R	isk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	(on	for	cual	(pw	ron	Low	
	DVT prophylaxis started	□ Yes □ No	□Yes □ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	□ Yes □ No
	Signature & Emp. No. of RN		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	80	· fetg	30	351	
	Signature & Emp. No. of Sr. RN	1 1.00	[100 V	000	Too	Nove	New	



Mr.ANANTHA KRISHNAN.P.N
79/Male/MHJ202381290
15/12/2023/IPH202302516
Dr.K.JAISHANKAR

DVT RISK ASSESSMENT

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

	Date	2012	2/10	01 12	2112	20/10	22)12	2212
		20m		20m	& bw		mone	Q Dm
S. No.	PARAMETERS	Of the	-guzii	7	01	004	1	0
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	٥	Ø	0	6	.0	Ö	
2	Bedridden recently >3 days or major surgery within four weeks	6	0	0	0	0	0	
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	Ø	0	0	О	Ø	Ø	
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	6	P	0	Ō	0	0	
5	Entire leg swollen (Assess for both legs)	ه	0	0	0	Ø	Ø	
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0	0	0	0	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	ر و	0	0	0	0	Ø	
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	ρ	0	S	0	Ø	b	
9	Previously documented DVT (Assess for both legs)	o	P	0	0	0	b	
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.	N	2	,2	<u>,</u> 2	٦	-2	
	FINAL SCORE	N	-2	, L	2	, L	-2	
Low R	isk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	المص	صلعا	رب	اسی	100	row	
	DVT prophylaxis started	□¥es ☑ No	□ Yes □ No	□ Yes	□ Yes □ No	□ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Signature & Emp. No. of RN	160	Star	Pol .	See S.	25	tillan	
	Signature & Emp. No. of Sr. RN	W/2	Jan	G	₩-n	Pay	180 184	



Medway Hospitals

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



Mr.Anantha Krishnan.p.n

79/Male/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





MHI/NUR/2022/046

here heart beat never stops...

MODIFIED MORSE FALL RISK ASSESSMENT CHART

					7	· ·		1		
Variables	Date	15/12/99	1912	16/12	18/13/38	18/12/2	4/12/2	17/143	A 12/23	18/12/18
variables	Time	13.0.	20.00	3,00	1400	20,00	8:00		2010	اما
History of falling	No	(6)	6	(0)	(ô)	(6)	(0)	7 0	0	<i>(</i> 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	(13)	(15)	(15)	(15)	(15)	(15)	15)	(15)	15
Intravenous Therapy /	No	M) 0 (0 (0	0)^(0	0	ð
Heparin Lock / Tubes Insitu	Yes	(20)	(20)	20	(20)	(20)	(20)	(20)	(20)	(20)
AMBULATORY AID)							
None / Bed Rest / Nurse Assist		(B)	0	0 (0	0	0	0	0	مح
Crutches / Cane / Walker	/	(13)	(15)	(\$5)	(15)	(15)	(15)	(15)	(15)	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT			-							$ \wedge $
Normal / Bed Rest / Wheel Chair		(6)	((0)	(0)	(o)	(b)	(0)	(b)	(q)
Weak		10	10)10	10	10	10	10	10	70
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS)		_				_	3
Oriented to own stability		(a)	(\circ)	(O)	(0)	(P)	0	(ô)	(e)	(o)
Overestimated or forgets limitations		15	15	· 15	15	15	15	15	15	15
MEDICATIONS										
Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives,	No	0	0	· 0	0_	0	0	0_	0	Q
immunosuppresent, anticonvulsants,	Yes	(15)	15	(93)	(15)	(15)	(15)	45)	(95)	(15)
anti-hypertensives, hypoglycemics and psychotropics			\mathcal{C}							
Total Score		695	65	65	66	65	b5	b6·	65	65
Low Risk (0 - 24)										
Medium Risk (25 - 44)										
High Risk (45 or above)	,		7.				~			
Signature & Emp. No. of RN			CAR.	1000		201	MAN	Contract of the second	8 511	Rage
Signature & Emp. No. of Sr. RN		STIR	1	12 Jan	-7	OON	100	000	00	To
, , , , , , , , , , , , , , , , , , ,	i	0 -	24: Low	Risk; 2	5 - 44: N	/ledium				Risk
and the second s		٠					_			

INTERVENTIONS	Date	isliche	12/19/	16/12	16/12	16/10/2	3/7/12	FF/12/20	12/13/23	18/12/13
Tick as per the Risk Score	Time	12.00	2010	8-00	1400	30,00	8.0	1300	50,100	8,00
Low Risk Interventions (0-24)								. /		1
Familiarize the patient with the immediate surround	lings			,		<i>\</i>	-/		\ \ \	~ /
Remind the patient to use call bell before getting ou						. 1	/		1	1
Keep the two side rails in the raised position at all t							_/_		· · ·	-
all patients regardless of age		<i>ノ</i>		,				/		
Keep the call bell, bedside table, water, glasses w	ithin the									
patient's easy reach		_	レ	2						1
Remove excess equipment or furniture to make	a clear	\		-				-		
path	. a cicai	_							V	
Keep the patient's bed in the low position at all time	e aveant				,					-
	a except								$ \sqrt{ }$	
during procedure	up for a								· ·	1
Teach fall-prevention techniques, such as sitting	up ior a	_		1					ام ا	-/
moment before rising from the bed			_		-				-	7
Bed wheels should be locked				- 1				-		1
Encourage family participation in the patient's care				7 /				<u> </u>	<u> </u>	1
Ensure that floor of the bathroom is dry and not slip			<u> </u>							Δ
Review medications for potential side effects t	hat can	_/		_ /	_				ا 🖊 ا	
promote falls			<u></u>							
Use safety belts during movement in wheelchair		~	<u></u>							1
The patients are not ambulated by themselves. The	ey are to			_ /						
be ambulated only with assistance		_				. /		~	. 🖊	1
Medium risk interventions (25 - 44)				/					<u> </u>	/
Apply all the low risk interventions		<u>~</u>	, /	,		ار ، ا				
Tie yellow fall risk tag in the bed and Wheel chair / S	tretcher				/					/
Make sure that proper transfer precautions are in			-			├ └∕				17
for heavy or debilitated patients in a bed or wheel		l		/		/	_			/
on a toilet seat	Chair Oi	💆				V				
	doctor		, ,	,		 			1	
Use restraints and bed monitors as ordered by the	abbioi				4					\sim
Allow the patient to ambulate only with assistance		-	1	-					_	£ /
Consider peak effects of the medications that effe		`								
of consciousness, gait and elimination when p	olanning		1/	/		. /	130	_		
patient's care	_	<u> </u>		_ /	_				1	
Do not leave patients unattended in diagno	ostic or		ا . ا				_			
treatmentareas		<u> </u>		/						\bigcap
Accompany the patient while going to bathroom										4 7
Advice the patient to use grab bars near the toilet,	bathtub,	l `	عصد ا	w		~	J.P.	/s.		/
and shower		NA	HA	FAK.	78	MA	X	N'A	NA	NA
Make sure the family and other visitors underst	and the	/		/						
restrictions mentioned above		\vee			/	1./				1
High-risk interventions (45 or above)					, T			*	<u> </u>	
Apply all the low and medium risk interventions	_			/		\ \ <u> </u>			レ .	7
Tie red fall risk tag in the bed, wheel chair and streto	her					-		-`-		
Locate the high-risk patients in a room close to the	_		<i>'</i>	/_	- ,	- ~		-		
station	Huises			/	/	1/				
	hla	 		/		, –				$-\sqrt{2}$
Answer these patients call bells as quickly as possi	nie	 	 	/	0	- -		<u> </u>	<u></u>	
Provide a commode at bedside (if appropriate)		 			- V					4
Urinal/bedpan should be within easy reach (if appr										
Encourage family members or other visitors to s	tay with	Lin	NA	ZP	717	NA	Kp	ND	المدا	P.W
them		NA	[[A, ,	. 6	101/	V **1	1,	12 A	NB	<u> </u>
If appropriate, consider using protection devices	s: safety	11/		7						_
belts	- 		لما	:/	¥/		Ø			/) ₁ .
Signature & Emp. No.	of RN	18/	W	N/A.	AN.	8)	8664V	AX/	180	5eN/1
		XX	021	1 12		307		100	10. P/	11
Signature & Emp. No. of	Sr. RN	-112W	LŹW	4/8				1		The same
									90/	



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MIT.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR



MHI/NUR/2022/046



MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date Time	18/12	18/12/2	19/12		19/12/23	20/12/2	Shrip		
	Titile	1/4 000	20.00	8.00	00 A1	20.00	8.00	14.400		
History of falling	No	(b)	0		0	9	10	9	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	(75)	15	15	45	15	15	15	15	15
Intravenous Therapy /	No	0	0	0	0	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	(Zô)	20	, 20	-30	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0 -	- 0	0	0	0	0	0	0
Crutches / Cane / Walker		(15)	-15	15	15	18	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT			_							
Normal / Bed Rest / Wheel Chair	ļ		D	0	0_	ا مورا	ہو۔	اسهر ا	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		6	9/	. 9/	0_	_9/	سور		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	(B)	15	15	15	15	,15	15	15	15
Total Score		85	65	105	65	65	68	66		
Low Risk (0 - 24)			-						-	
Medium Risk (25 - 44)										
High Risk (45 or above)				$\overline{\mathcal{L}}$	<u></u>	\				
Signature & Emp. No. of RN		Opel	By'	POC+	\$00F	\$\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	30	2 jh		
Signature & Emp. No. of Sr. RN		1080	Nee	136	ما المام	1254	24	ée		
		0 -	24: Low	Risk; 2	5 - 44: N	ledium	Risk; 45	or abov	/e: High	Risk

				2						
	Date	10/12	18/12/	20/10	19/12	a/12/2	20/12/2	1381		1
INTERVENTIONS	Date	10/	, ",	19/12	1 11 -	TIL		2ª		
Tick as per the Risk Score	Time	14,8	20.00	8.00	14.00	20,00	\$.0°	Why	'	
		1		0.00	P1. 0 -	<i>∞</i>	Ψ	100		
Low Risk Interventions (0 - 24)					V			(
Familiarize the patient with the immediate surround		4	,-				<u> </u>			
Remind the patient to use call bell before getting ou				0/		~				
Keep the two side rails in the raised position at all t	imes for									
all patients regardless of age		0	,	<u> </u>	ļ		<u> </u>	 		
Keep the call bell, bedside table, water, glasses w	ithin the	/								
patient's easy reach		-/-	1 7				<u> </u>			
Remove excess equipment or furniture to make	a clear	//			/		/	_		
path		<u> </u>	<u> </u>		ļ	<u> </u>		/	<u> </u>	-
Keep the patient's bed in the low position at all times	s except		_	ر .ا	- T			1		
during procedure		-	/_			<u> </u>				
Teach fall-prevention techniques, such as sitting	up for a	/		_	ہ ا	1	/	"		
moment before rising from the bed		1		£	6			V		
Bed wheels should be locked						<u> </u>			ļ	
Encourage family participation in the patient's care						\sim				
Ensure that floor of the bathroom is dry and not slip	pery				V_	<u> </u>				
Review medications for potential side effects t	hat can									1
promote falls						✓				
Use safety belts during movement in wheelchair		//	~			V				
The patients are not ambulated by themselves. The	ey are to									
be ambulated only with assistance	-									
Medium risk interventions (25 - 44)			<u> </u>				<u> </u>			
Apply all the low risk interventions			/	<u>ب</u>		~	/	_	1	
Tie yellow fall risk tag in the bed and Wheel chair / S	tretcher		1	<u> </u>				<u> </u>		
Make sure that proper transfer precautions are in			 	1	_	<u> </u>		 		
for heavy or debilitated patients in a bed or wheel		"		·	(V	🗸		<u>/</u>]	
on a toilet seat	onan o		-	,	i			-		
Use restraints and bed monitors as ordered by the	doctor			c_	-		1	 		
Allow the patient to ambulate only with assistance	300101	-		 _		-	-		 	
Consider peak effects of the medications that effe	oto lovol	 	 	<u> </u>	<u> </u>	 ~	 	V	-	
of consciousness, gait and elimination when p		/	_	ر ۽ ا		🗸	1	L		
patient's care	natiming	_	_				ļ	l .	i	
	notic or	 / 		 	-		 	1	-	
Do not leave patients unattended in diagno	osuc or		·/		<u>-</u>					
treatment areas		 	_	╄						
Accompany the patient while going to bathroom	- 11-1I-	 		~		<u> </u>				
Advice the patient to use grab bars near the toilet, I	oatntub,	/				~		V		
and shower		├ ′─	-مرا	-	<u> </u>	<u> </u>	<u> </u>	1	<u> </u>	
Make sure the family and other visitors underst	and the	ł					/	–		ł
restrictions mentioned above				9/		ļ		1	ļ	
High-risk interventions (45 or abovc)		1/					/	1 -	<u> </u>	-
Apply all the low and medium risk interventions				-2	<u> </u>	<u> ~ _ </u>	<u> </u>	_		
Tie red fall risk tag in the bed, wheel chair and stretc			<u> </u>			<u> </u>			ļ	
Locate the high-risk patients in a room close to the	nurses'	/			 			1	1	
station		ļ	<u> </u>		<u> </u>	<u> </u>	_	ļ		
Answer these patients call bells as quickly as possil	ble		<u> </u>			\sim		~		
Provide a commode at bedside (if appropriate)				-		~				
Urinal/bedpan should be within easy reach (if appro		L^{\prime}				<u> </u>				
Encourage family members or other visitors to s	tay with			/		~	7]	
them				<u> </u>	<u> </u>	L	_		L	L
If appropriate, consider using protection devices	s: safety		↓		 		_		1	
belts	-	ŀ "/	/						}	
Signature & Emp. No.	of RN	100	ASO.Y.	82Cm	120	A w	15%			
		X X	8/2	1000	F 000"	1 20V	"A"		K	
Signature & Emp. No. of	Sr. RN		يستجفه إ	Não	100	يد عوا ا	بن م	18/		
		100		200	7			- 0 4		



Medway Hospitals

The way to better health

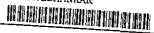
(A Unit of United Alliance Healthcare Pvt Ltd)

MI.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290

15/12/2023/144202302516

Dr.K.JAISHANKAR



MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	2012	21/1	2/25		22/	223	92112-		
variables	Time -	≱ Dm	M	Ė	N	M	5	Λ).		-
History of falling	No	8	0	9	,ø	8	~9	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	1,5	15	15	15	CHS	15	15	15	15
AMBULATORY AID		0_	0	0	0	0	0	0	0	0
None / Bed Rest / Nurse Assist Crutches / Cane / Walker		1,5	157	سظل	15	<u>√15</u>	V 5	\15	15	15
Furniture		30	30	30	30	30	30	30	30	30
Intravenous Therapy /	No	0	0	0	0	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	29	20	26	z 0	20	20	\20	20	20
GAIT		0 _	0	0	0 /	0.	9		, 0	٠ 0
Normal / Bed Rest / Wheel Chair Weak		10⁄	10	40	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS	_	0/		æ	8/	0	&	\o	0	0
Oriented to own stability 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	10	رم	9	0	0	0
immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	Yes	15	15	15	15	15	15	US	15	15
Total Score		44	F60	60	60	po	\0\0	60		
Low Risk (0 - 24)			-							
Medium Risk (25 - 44)								-		
High Risk (above 45)		A	V		V.)		22		•	
Signature & Emp. No. of RN		v / ///	Spen	8 2 y	V/A)	Co.	S. S.	域		
Signature & Emp. No. of Sr. RN	· . ·	1/10.	200	1000	1/XA	(mix	180	120		

		Date	۲	r 1	,	_				, ,	,
INTERVENTIONS	ļ. <u>.</u>	Jale	2012	20/1	2/2-	B	12	12	23	<u> </u>	<u>'</u>
Tick as per the Risk Score	7	Time	7000 NW	M	F	€,	Σ	15	N		_
Low Risk Interventions (0 - 24)											_
Familiarize the patient with the immediate su	urrounding	s									
Remind the patient to use call bell before get											
Keep the two side rails in the raised position	n at all time	es for								1	
all patients regardless of age		_ 4!	 	 							
Keep the call bell, bedside table, water, gla patient's easy reach	asses Withii	n tne									1
Remove excess equipment or furniture to	n make a	clear	<u> </u>	 		 	-				
path											
Keep the patient's bed in the low position at	all times ex	cept									
during procedure						1			<u> </u>		<u> </u>
Teach fall-prevention techniques, such as	sitting up	for a		l				! !			
moment before rising from the bed Bed wheels should be locked	-		 							 -	
Encourage family participation in the patient	t's care										
Ensure that floor of the bathroom is dry and		v		-					ř		
Review medications for potential side ef		_									
promote falls						<u> </u>					<u></u>
Use safety belts during movement in wheeld	chair								<u></u>		
The patients are not ambulated by themselv	ves. They a	re to									
be ambulated only with assistance											•
Medium risk interventions (25 - 44)								_			
Apply all the low risk interventions Tie yellow fall risk tag in the bed and Wheel or	shair / Strot	chor.		 	ļ	 -				<u> </u>	<u> </u>
Make sure that proper transfer precaution										<u> </u>	
for heavy or debilitated patients in a bed or											
on a toilet seat				<u> </u>							_
Use restraints and bed monitors as ordered	by the doc	tor_	<u>-</u>								
Allow the patient to ambulate only with assis				ļ	ļ						<u> </u>
Consider peak effects of the medications the											•
of consciousness, gait and elimination of patient's care	wnen piar	ining		1	}						
Do not leave patients unattended in	diagnosti	c or									
treatment areas	alagilooli	.		1							
Accompany the patient while going to bathr	room										
Advice the patient to use grab bars near the	e toilet, bat	htub,									,
and shower											<u> </u>
Make sure the family and other visitors u	understand	d the	1	1]				l		
restrictions mentioned above High-risk interventions (above 45)											
Apply all the low and medium risk intervention	ons		√	·/-	<u>ب</u>	1-		<u> </u>			
Tie red fall risk tag in the bed, wheel chair an		,	<u> </u>				-				
Locate the high-risk patients in a room close				~		<u> </u>		<u>~</u>			
station			من ۽	V	<u> </u>	<u></u>	//	~			
Answer these patients call bells as quickly as			\mathcal{L}		/		7	I			
Provide a commode at bedside (if appropria					V				<u> </u>	<u> </u>	
Urinal/bedpan should be within easy reach			<i>✓</i> ′	'V				1	<u> </u>		<u> </u>
Encourage family members or other visitor them	ors to stay	with	<i>✓</i>	رز ا	/						1
If appropriate, consider using protection	devices: s	afety				<u> </u>					
belts		y ,		~	-		1.1				
Signature & Em	no. No. of	RN	is bo	(an	ei	7.35 7.35 7.35 7.35 7.35 7.35 7.35 7.35	11/1/1	ROW	N.		
<u> </u>	-		15.90°	/ N	24		V/1/2	-10y	17 30 V	 	<u> </u>
Signature & Emp. I	NA ~4 0-	DNI	- 1 -CA	1 1 -	4 61	Ork	6.7 7991		1 1 1 2	,	1

DRUG CHART

The way to bet	t er nealth Mr.ANANTHA KRIS	HNAN P N	- <u>-</u>														<u> </u>		<u> </u>
Name of the Patient	79/Malc/MHI2023812 15/12/2023/IPH20230	290	ļ		f	Age		Sex	B	Bed No)						, i	, *	\ \ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\
Clinical Diagnosis	Dr.K.JAISHANKAR			IP	No	•••••	•••••	Ht	W1	t	****						,	•	,
Primary Consultant Name	<u> </u>			PI	D No					••••••								1,1	``\
Name of the Medicine	Dose	Route	requency	40 /12/:	25	20/12	.[27_	23_	12 23	2311	2/23	·							11
In Dyfor	Toy	IV!	10-0-10-0				y Pm		1 1	Stop '									1,
Ti force	507	Tu 1	اسم		ON T	E	3	YAP YAP	1 pm	Jim 1	apı			\coprod	\perp				
T. ALDAETONE	254	Ph	1-00.			3		8 APT		ġĘ.									
7 Supper	8-7	Pho	G-0-1.		oy ixi		8		8		2040				\perp				\perp
-t.VDILIV	300-2	Plo	1-01.		301	3	 K	38	8/ 2m		200								
T. Nusom	Zog	P/0 0	0-10.			,,,,,	**		pr	M	®								
T.NAC	600-7	96	(-0 1.		9/3	8	R R	81	8 Vr	80	گ								
Syp. LACTIMED	20 mg	10	1-1-1.		מיו	. 1 /		8 N	2/ S/	10 W.8	60 20 ED								
T. INDERPL	Zoy		1-01		2	E	34	18 h	8	8.0	200								
TROFFAR	530		1-01.		gy.	3	1 1 .	81	8	8.00	Spac	9							
Administered by (Nurse Sig		•			1	D O	1/2	80	N Q	EX W	2		1						
Verified by (DMO Signature	e):					K.	<u> </u>	V	jou				++				_		
Nurse Signature : 1	251	· DN	/IO Signatu	ire:	19/51 193268		1		Primar	у Соп	sultar	nt Sign	ature	: £	er (9	3268		
						BIZH			Primar	_	sultar	nt Nam	e	: De : 20	;_F_; _1_/	JAI	JHM A IM	KAR.	
Date & Time : 2 0 //2	12000	ァ _イ ・、 Da [・]	te & Time					z	Date & Reg No					:20)/ <i>DF</i>	≥E(e) '	رسد، ۵۵	170-	
	اأاعر						, i	√	neg ive						+94	-48			
Allergic to	×(ι,	Δds	verse Reac	tion if an	W		V1)												



SOS MEDICATIONS

DATE	TIME TO BE GIVEN	DRUG (APPROVED NAME)	DOSE	ROUTE / OTHER DIRECTIONS	DR. SIGN.	GIVEN BY NURSE TIME / INITIALS
2012/2	9L80PM	INFLOY-TOR	2011	<u>I</u>	Dn-MARISH	
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, <u>, , , , , , , , , , , , , , , , , , </u>				,		
		-				

SOS MEDICATIONS

	TIME TO BE	DRUG		ROUTE / OTHER	T	GIVEN BY NURSE
DATE	GIVEN	(APPROVED NAME)	DOSE	DIRECTIONS	DR. SIGN.	TIME / INITIALS
1				,		
1						



DRUG CHART

Mr.	ANANTHA	KRISHNA	NDN			_														_						- ,
	Male/MHI20						Aa	9		S	ex		Bed I	No										1	æ	ļ
15/	12/2023/19						_																		٠,	,
Clinical Diagnosis : _{Dr.8}	JAISHANK	AR .				, No		• • • • • • • • • • • • • • • • • • • •		•••••	Ht		₩ t												΄,	
Primary Consultant Name:											·····				•				_							<u>.</u>
Name of the Medicine	Dose	Route	Frequency	4	Inl	<u> </u>	2	2 12	123	,	23	12/23				-							-			,,
C. AWAY TOX	,	Plo	117		(2)	*	8		5mJ	8	N B	500														
C. ANDY POX T. DYTOR D. Pan G	10 mg	Plo	8 pm 4 pm	;			80	├	<u>بر</u>		e0 16	5 1														
7-Pan a	and	po	100	7																					\perp	
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																										· ·
Administered by (Nurse Signature	e):	<u> </u>	.1.			1/4	O)		X	0/1	20 W	, s												ĺ		
Verified by (DMO Signature) :							Øà.	,	V		1001	1														
Nurse Signature :		[OMO Signat	ure	: ·	1/2	ار ا	18	· 85	<u></u>	, 1.	Prima	ary Co	onsu	ıltan	t Sig	nati	ure	:	/	12	7	w	۱	1	
Nurse Name : SN. SR	PRIYO	10 10	OMO Name		: D) f	/A			•			ary Co		ıltan	t Na	me		:	l) t					avl	î.
Date & Time : Walls	_		Date & Time	!	: 2	alid	23	۵	<u></u> 81	D V	•	Date Reg I	& Tim No.	ne 					:		111 19		0 0 8	'A &	<u> </u>	
Allergic to		А	dverse Rea	ctio	n, if a	ny	•••••) -(c	J												1			



SOS MEDICATIONS

Ţ	· (, – ,	TIME TO BE	DRUG		ROUTE / OTHER		GIVEN BY NURSE
	DATE	GIVEN	(APPROVED NAME)	DOSE	DIRECTIONS	DR. SIGN.	TIME / INITIALS
	· //						
	/"					,	
1			1	- ,			

SOS MEDICATIONS

DATE	TIME TO BE	DRUG	DOSE	ROUTE / OTHER	DD SIGN	GIVEN BY NURSE
DAIE	GIVEN	(APPROVED NAME)	DOSE	DIRECTIONS	DR. SIGN.	TIME / INITIALS
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Mt.Anantha krishnan.p.n

79/Mulc/MH1202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





PATIENT AND FAMILY EDUCATION RECORD

Assessment To be f						plines. U								
Barriers to	Lea	arning								Plan t	o A	ddr	ess	s Factors
None		Vision	/ He	arin	g lin	nitations	; 			Use	of li	nterp	rețe	er
Limited Reading Abilities		Physic	al b	arrie	rs] Eđu	cate	fam	ily	
Religious / Cultural Factors		Langu	age	barr	iers] Sim	ple L	ang	uag	e
Congnitive Limitations - unable to		Low m	otiv	atior	ı / d	esire to	leari	1		Writ	ten l	nstu	ctio	ns
understand and follow directions														
Completed By : Date 15 12 23 Tim	2:3	2:20 Nurse Signature :												
				_		_								
Learning Record											_			
Need		Date	١	Visit	1	Date	\	/isit	2	Date	'	Visit	3	Signature
		15/12h	L	P	0	1612	رد	Р	0	1412	Ļ	Р	0	
Disease		- 												Doctor
☐ Information on														Anish Nelson
Disease / Diagnostics			P	ගැ	(C)		Þ	מכו	W		P	Ø	V	∰r, Anish Nelsor Reg. No: 88434
Treatment								00	r		0	00	V	
Medications	-		P	D D	VD		. –	00			ý	90	V	Doctor / Nurse
Information on Safe and							70			_				, '&\
Effective use of medicines	_		P	20	VP		P	92	~		g	Q)	V	NOS STORY
information on drug / drug and			1						,					
drug / food interactions	_													
☐ Discharge Medications														
Surgical Instructions														Nurse
☐ Pre - Operative Instructions														
Post - Operative Instructions												-	ļ	
(Wound / Dressing Care)														
Pain Management														Nurse
Reporting of pain	_7		P	ρD	>		P	80	7		P	00	>	Nae-
Pain Management		-	P	۵۵	/		P	QĐ	7		ρ	OD	abla	ozy
Safe and effective use of medica	ı	-									Ť			Doctor / Nurse
Equipment (if required)	[
Name of Equipment														
Rehabilitation Techniques	l													

		Date	L١	/isit	1	Date	L١	/isit	2	Date	V	/isit	3	Signature
			L	Р	0		L	Р	0		L	P	0	
Nutritional Guidance														Dietician
Diet Instruction for pa Nutritional risk	atients at		P	91	J.		P	عر	2		1		\ \	oria Cetherine John
Diet advice for home	_	_	_		Ħ					-	_	=]	Nurse Nitian
Discharge Planning														
Self care														
Follow up	<u> </u>													
Reporting Concerns immunizations														
☐ Parenting education														•
Others	_	 	\vdash	\Box	Н				Н					
Risk Factor Reduction			\Box		П				П	_				· ·
☐ Smoking Cessation	• •			П	П		4		П	,*	. •			Doctor
☐ Weight Control									П					
					П				П					
☐ Hypertension														
Other Risks			\vdash	Г	П			Г		_				
OUTCOME (O) - RD - I Written Material given	Return Demons	stration,				W-Wr								
OUTCOME (O) - RD - I	Return Demons	stration,												
OUTCOME (O) - RD - I	Return Demons	stration,	V - \											
OUTCOME (O) - RD - I Written Material given	Return Demons	stration,		Verb	aliz	ed Uni	ders					Per	ndi	ng NA
OUTCOME (O) - RD - I Written Material given	Return Demons	stration,	V - \	Verb	aliz		ders				1	Per	ndii	ng NA
OUTCOME (O) - RD - I Written Material given	Return Demons	stration,	V - \	Verb	Diet	ed Uni	ders				1 1	Per	ndi	ng NA
OUTCOME (O) - RD - I Written Material given Reports Given :	Return Demons	stration,	V - \	[Olet ST S	Advice	ders				n —	Per	ndii	ng NA
OUTCOME (O) - RD - I Written Material given Reports Given : Discharge Summary ECG Report	Return Demons	stration,	V - \	Verb	Diet ST S	Advice	ders				n	Per	ndii	ng NA
OUTCOME (O) - RD - I Written Material given Reports Given : Discharge Summary ECG Report Doppler Report	Return Demons	stration,	V - \	Verb	Diet S	Advice Scan Fil	eport	tano				Per	ndi	ng NA
OUTCOME (O) - RD - I Written Material given Reports Given : Discharge Summary_ ECG Report Doppler Report X-Ray Report	Return Demons	stration,	V - \	[Diet CT S	Advice Scan Re Scan Fil	eportim Rep	t				Per	ndii	ng NA
Reports Given: Discharge Summary_ ECG Report Doppler Report X-Ray Report X-Ray Film	Return Demons	stration,	V - \	[Diet CT S	Advice Scan Re Scan Fil	eportim Rep	t t		Giver				ng NA

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Assessment



MT.ANANTHA KRISHNAN.P.N 79/Malc/MHI202381290 15/12/2023/IPH202302516 Dr.K.JAISHANKAR



PATIENT AND FAMILY EDUCATION RECORD

To be filled by concerned disciplines. Use key below

Barriers to	Le	arning								Plan t	o A	ddr	es	s Factors
None		Vision	/ He	arin	g lin	nitations	- -			Use	of la	iterp	rete	er
Limited Reading Abilities		Physic	al b	arrie	rs			_] Edu	cate	fam	ily	
Religious / Cultural Factors		Langu	age	barri	ers		•] Sim	ple l	_ang	uag	e
Congnitive Limitations - unable to		Low m	otiv	atior	ı / d	esire to	learı	1] Writ	ten	Instu	ctic	ons
understand and follow directions				~						0.11	า			
Completed By : Date 18 19 Tin	ne	Ŋ	۰0	_	lurs	e Signa	ture	·:_			1			
Learning Record										-		-		······································
Need		Date	١	/isit	1	Date	Ţ	/isit	2	Date,	Β,	Visit	3	Signature
,		18/12/	, L	Р	0	alvi	L	Р	О	20/12/	T	P	0	
Disease					Г						Ţ			Doctor
Information on							·							0
Disease / Diagnostics			`								p	OV.	\ \ \	K.83
Treatment			D.	20	vI		Ь	00	1		1	Π		134557
Medications)D .	1		0	00	Г		n	ررا		Doctor / Nurse
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Effective use of medicines												l	١,	Jass
☐ Information on drug / drug and													Π	
drug / food interactions					-									
☐ Discharge Medications														
Surgical Instructions						l e					P	pp		Nurse
Pre - Operative Instructions														
Post - Operative Instructions									Γ					DAWY
(Wound / Dressing Care)	•												L	
Pain Management		_												Nurse
Reporting of pain			P	ÞΦ	7		P	OD	V		þ	bo	γ	
Pain Management			P	PD	\checkmark		_0	OD	V		10	อทู	V	024
Safe and effective use of medica	al						T							Doctor / Nurse
Equipment (if required)		<u> </u>					_	<u> </u>	_		_			
Name of Equipment														
Rehabilitation Techniques				ŀ								1		

			Date	١ ١	∕isit	1	Date	۱ ۱	/isit	2	Date	١,	/isit	3	Signatur
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Nutritional Guidance		Ì									1				Dietician
Diet Instruction for Nutritional risk	patients at	t		7	øχ	ည		U	عر حد	ט		n	مد	ħ.	ria Cathern Con Cenior Diagram
Diet advice for hom	ie -							_				4	6	P	Nurse
Discharge Planning															
Self care		[
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Mr.ANANTHA KRISHNAN.P.N 79/Malc/MHI202381290 15/12/2023/IPH202302516 Dr.K.JAISHANKAR



IN-HOUSE TRANSFER FORM

Part	A (to be filled by Nu	rses)					
Date	e of Transfer: 10 10		.oo_Tra	ansferred	from:	?cv)	<u> </u>
	gnosis:	Severe	coleyro	ghev	Arc 24	arons/ to DM	2
Vital	- Signs: T emp:_ 哟&^ (°F		56	(beats/n	nin) BP:	(mmHg) Respi	ration: 🕰 (breaths/min)
Part	B (to be filled by Phy	/sicians)	Any Critic	al Investig	ations:		
	Check for			Trai	nsferring Docto	r	Receiving Doctor
Resp	iratory (Breath sounds)	Clear	Crepitat	tion 🔲 F	Rhonchi O	hers:	Yes No
Abdo	omen	Soft	Tender		Distended 🔲 Of	hers:	Yes No
Hear	t Sound	Normal [Feeble	e Loud	d Others:	granuar +	Yes No
CNS		Consciou	ıs 🗌 Or	iented	GCS Sco	re:	Yes No
	Surgical Patients plicable)	Surgical Site:	Heal	thy 🔲 S	oakage O	thers:	Yes No
	<u> </u>	Prese	nt Medic	ation (for	Medication Re	econciliation)	
S. No.	Current Medic	eation	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
	7. PROSMERMY)	8 arg	ρ,	0-0-1	18/12/28 @10:30	☐ Yes ☐ No
2	NESS. LEVOUN)	0,682	Pin	1-1-1		∠ Yes □ No
3	NB4s. Romazi	>r4"	0.52	Pm	1-0-1		☐ Yes ☐ No
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		<u> </u>					☐ Yes ☐ No
	·				'	i	☐ Yes ☐ No

Additional Det	tails (if any):			_		
ı							
							
Patient Condi		<u>′ </u>	Sick-need urgent care Othe				
Transferring	Sign	<u> </u>	Name Dr. Anish Nelson	Reg. No. Dr. Anish Nelson	Date	<i>3</i> 77	Time
Doctor	10	mbr	Reg. No: 88434	Reg. No: 88434	18/1/3		Y. 3°
Receiving Doctor			Dr. Moharad hydros	182201	18/	12/23	11.30
Part C (to be f	illed	by Nurses)					
Check for			Transferring Nurse]		ng Nurse
Drains		Chest A	bdominal Others:		<u> </u>	Yes	No
Respiratory		Air Way Type: Oxygen Therapy	- =	::li/m	nin	Yes	No No
NG Tube / Oral		Yes No	For Feeding Gastric Suction	Fluid Restriction		Yes	. []_¥6°
Foley's Catheter		Yes No				Yes	No 🗌
Intravenous Acc	ess	Peripheral Li	ne Central Venous Line Others:			Yes	i ☐ No
Pressure Injury			If Yes, give details:			Yes	
Score		Fall Risk: 50	WELLS: NEWS / PEWS:			Yes	No No
Patient Belongin	igs ———		If Yes, give details:		_	Yes	;
Handover Detail	s		inistration Record explained: Yes [c Reports handed over: Ves No			Ves	No D
Patient Attendan Informed	nt	Yes No	If No, give details:			Ves	No No
Additional Det	tails (if any):					
		001					
	Sign		Name	Emp. No.	Date		Time
Transferring Nurse		Ox	9.00 p. 2	019	18/13	1/23	1.00
Receiving Nurse		k- will	Jor a- 2 E. Cathrine	0207	18	12/23	





Mr.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290 15/12/2023/IPH202302516

Dr.K.JAISHANKAR





Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 15/12/23	Time: [ग्राह					
Checklist	Yes	No	NA	Ac	ction / Remarks		-
MEDICAL							
Daily Consultant Visit						_	
Plan of care discussed	1						
Discharge Planning				_			_
Others if any							
-NURSING							
Safety Precautions Ensured	-						
Care of Lines and Tubes	17						
Infection Control Measures	/						
Skin Care							
Response to assistance							
Others if any						_	
DIETICIAN							
Diet Adequate							
Special Request	1,						
PHYSIOTHERAPIST							
Available for Assistance for Activities of Daily Living		7					
Others if any	7						
PATIENT CARE SERVICES							
Room Cleaning satisfactory				-			
oom Amenities Adequate							
Billing Update available							
Non-Availability of any service							-
Spiritual Needs (if yes specify)							
Others if any							
		Inte	r Dis	ciplinary Team Members			
	Signatur	e	_	Name Dr. Anish Nelson Reg. No: 88434	Reg. / Emp. No.	Date	Time
Doctor	Aus	1/2			Reg. No: 88434	15/12/23	
Nursing Staff	100	100		JayADEV 1. J	0002	(5/12/03	12-30
Dietician	<u>~ @</u>			Capter Distition	567	15 Mm	1410
Physiotherapist	G.B.	Athay _		AKASH-G-1	०२ ९६	15/12/23	14:00
Patient Care Service Staff							



r.Anantha krishnan.p.n

)/Male/MHI202381290

5/12/2023/IPH202302516







FAMILY COUNSELLING FORM

CONSU		JAI SHAN KA	P. DIAGNOSIS-T2DM / HTW/ EEVER!			
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
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Blobs	poclop?	SON	Pr. como iras marmo 70 Romes		July	Jung Sam







Every heart beat counts

VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME:

Mr.ANANTHA KRISHNAN.P.N 79/Male/MHI202381290

15/12/2023/IPH202302516

AGE / SEX:

Dr.K.JAISHANKAR

IP No. / UHID No

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Every heart beat counts

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

VIP SCALE (VISUAL INFUSION PHLEBITIS)

Mr.ANANTHA KRISHNAN.P.N PATIENT NAME 79/Malc/MHI202381290

15/12/2023/IPH202302516

AGE / SEX:

Dr.K.JAJSHANKAR

IP No. / UHID No

Ward / Bed No.

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

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I/A Unit of United Alliance Healthcare Pvt Ltd)

VIP SCALE (VISUAL INFUSION PHLEBITIS)

Mr.ANANTHA KRISHNAN.P.N

15/12/2023/IPH202302516

PATIENT NAME: 79/Male/MHI202381290 IP No. / UHID No

AGE / SEX:

Dr.K.JAISHANKAR

Ward / Bed No.

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

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Chical Pharmacist

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Mêdway Hospitals The way to better health (A Unit of United Alliance Healthcare PM Ltd)



Mr.Anantha krishnan.p.n 79/Malc/MHI202381290

15/12/2023/IPH202302516

Dr.K.JAISHANKAR

MEDICATION ADMINISTRATION RECORD

Drug	Chart:	of1	Height (cms): <u>+168</u> Weight (kg): <u>+60</u>							<u> </u>
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				NK	on.	; ••	٠.	Name Reg.	Dr. Anish I	Nelson 88434
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 Write in Sign ar No pres 	BLOCK nd enter l scription	me when prescribing drug LETTERS, clearly and legibly MCI registration no. or apply seal should be altered / overwritten mat when writing time	2. Nurse 3. For ne follow 4. Standa Q8hrly 11:00h	in-charge w prescrip standard ard Timing : 06:00hrs, irs, 17:00hr	should ver otion, follow timings gs: Q24hrly 14:00hrs, 2 s, 23:00hrs	v the timings : 10:00hrs, Q :2:00hrs ar 0: , Q4hrly: 02:0	ort on daily basis of doctor's prescr 12hrly: 10:00hrs, 22: 9:00hrs, 14:00hrs, 2: 00hrs, 06:00hrs, 10:0	:00hrs or 0 1:00hrs, Q(6:00hrs, 18:00h 6hrly: 05:00hrs,	rs,
	•	Stat / C	once O	nly'/ P	remed	ication	Drugs		_	
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Clinical Pharmacist Medway Heart Institute

Clinical Pharmacist Medway Heart Institute

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Clinical Pharmacist Medway Hearl Institute

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	Area in-charge Nurse Signature				fa	100		3/	nge.	25		

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Clinical Pharmac at

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Clinical Pharmacist Ledway Heart Institute

Date → To be filled by Nursing Staff only. Sign and time given ANTIMICROBIALS To be filled in by Doctors only Time **↓ DRUG NAME** (answer = put) 125 MAGNEY RUTE Dose Route Frequency 1.5 1-0-1 Start Date & Time Dr. Sign & Reg. No. / Seal Additional Info: **DRUG NAME** 8<u>00</u> 7. A ZEE 1. × 30m Dose Frequency Route -500× Pro 1 - 0- D Start Date & Time Dr. Sign & Reg. No. / Seal 15/12/23@12.40 Stop Date & Time m/on Additional Info: **DRUG NAME** 800 x 30ms T. Tamifu Route Dose Frequency 1-07 Stan Date & Time Dr. Sign & Reg. No. / Seal 15 12 2.20 12.40. Stop Date & Time 00.00 Additional Info: 20.h0 DRUG NAME 7-1-# Dose Route Frequency Dr. Sign & Reg. No. / Seal 🦠 Start Date & Time Stop Date & Time Additional Info: **DRUG NAME** 802 ENEMA Route Dose Frequency Dr. Sign & Reg. No. \Seal Start Date & Time Stop Date & Time Additional Info: Area In-charge **Nurse Signature:**

To be filled by Nursing Staff anly. Sign and time given Date -> **ANTIMICROBIALS** To be filled in by Doctors only Time \ DRUG NAME _ MONOCEF. 8.00 Dose Route Frequency $z \mathcal{I}$ 14 Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time DO-00 Additional Info: **DRUG NAME** T. RCIFAX. 8.00 Route Pro Dose Frequency νآ 2204 P Start Date & Time Dr. Sign & Reg. No. / Seal . 2000 Stop Date & Time 91810 Additional Info: **DRUG NAME** Dose Route Frequency Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: **DRUG NAME** Dose Route Frequency Start Date & Time Dr. Sign & Reg. No. / Seal ٠, Stop Date & Time Additional Info: **DRUG NAME** Dose Route Frequency Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: Area In-charge Nurse Signature:

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		i	PARENTE	ERAL INFL	JSION F	PRESCRIPTION AND ADMI	INISTRA	ATION	RECO	RD			
Date	Time	Intravenous	Volume	Rate /		Additive Drug			Do	ctor	Adr	ninistratio	n
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20/1283	872	Diabetic dief	4-82	134756					

NURSE IDENTIFICATION RECORD

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

				r					$\overline{}$
Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
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15/2/23	Evening	S. Allwin granagrace	0162	Ø.	19/12/28	Evening	A. ALBINUS	0088	2
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16/1423	Morning	pohamoy	2-752-	R	20/2/23	Morning	B. Vanin'	0/90	Cert
16/12/22	Evening	S. Allwingrace	062	8	20112B	Evening	popultage "	6146	
16/12/23	Night	Paremalatha	021)	R		Night	U 0		
11/2/03	Morning	Autri	0282	M.		Morning			
17/2/23	Evening	S. Allwin from trac	<u>0160</u>	A .		Evening		,	
17/12/22	Night	S. Perema Votra	0211	8		Night	·		
8/0/23	Morning	Days: R	015 8	<u>Q</u>		Morning			3
18/12	Evening	R. Sustman	020	R.		Evening		<u> </u>	
والالعا	Night	Parithan	0092	Pall		Night			♥)









Where heart beat never stops...

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REQUISITION FOR MEDICINE

Mr. Anantha

AOQ NUDIN

18/12/23.

Age / Sex Consultant Name

Name of Patient

UHID No. : Room No .

IP No.

Consul	tant Name	: Room No.:	(0
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Where heart beat never stons...

(A Unit of United Alliance Healthcare Pvt Ltd)

REQUISITION FOR MEDICINE

IP No.

Name of Patient : MAL . Novitiva kailhroin -

DOA

Age / Sex : T

Consultant Name:

UHID No.: Room No.: ((t))

	Toom vo.: (E)		
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Medway Hos 15/12/2023/194202302516

The way to better | Dr.K.JAISHANKAR

Mr.Anantha krishnan.p.n 79/Malc/MHI202381290

DIMPRER Ensy Spill 274 MIBUMIN 2. 1. -



Kodambakkam

@medwayhospitals | @medway-hospitals | @medwayhospitals ₱ @MedwayHospitals **Medway Group of Hospitals**

Mogappair

Kumbakonam Chengalpattu



Villupuram

Medway Centre of Excellence (Chennai) Heart Institute

044 - 4310 8959

Institute of Pulmonology 044-2473 4451

94457 94457

1800 572 3003

MHI/PHARM/2022/060









Where heart beat naver stops...

(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290

Name of Patient 15/12/2023/IPH202302516

Dr.K.JAISHANKAR Age / Sex }}}

Consultant Nan.

REQUISITION!

IP No. DOA

UHID No.:

Room No.:

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Where heart beat never stone...

(A Unit of United Alliance Healthcare Pvt Ltd) Mt.Anantha krishnan.p.n REQUISITION FOR

Name of Patient

79/Malc/MHI202381290

15/12/2023/IPH202302516

Age / Sex

Consul ant Name

Dr.K.JAISHANKAR

IP No.

DOA

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UHID No.: Room No.:

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Where heart beat never stops...

(A Unit of United Alliance Healthcare Pvt Ltd) **REQUISITION FOR MEDICINE**

IP No.

Name of Patient

Age / Sex

UHID No.:

Consultant Name:

Room No.: CO

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(A Unit of United Alliance Healthcare Pvt Ltd)





MHI/PHARM/2022/060



Where heart best never stops...

REQUISITION FOR AMERICANE

MI.ANANTHA KRISHNAN.P.N

Name of Patient : 79/Male/MHI202381290 15/12/2023/IPH202302516

Age / Sex : Dr.K.JAISHANKAR

DOA :

IP No.

Consultant Name:

Room No.:

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Where heart best never stops...

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(A Unit of United Alliance Healthcare Pvt Ltd)

REQUISITION FOR MEDICINE

Name of Patient :

Age / Sex

Consultant Name :

IP No.

DOA

UHID No.:

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Nurse Name







(A Unit of United Alliance Healthcare Pvt Ltd)

REQUISITION FOR MEDICINE

Name of Patient :

Age / Sex :
Consultant Name :

IP No. DOA

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Room No.: au.

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Nurse Name



Medway Hospitals

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(A Unit of United Alliance Healthcare Pvt Ltd)







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REQUISITION FOF

Name of Patient

Mr.ANANTHA KRISHNAN.P.N 79/Malc/MHI202381290

15/12/2023/IPH202302516

Dr.K.JAISHANKAR Age / Sex

UHID No.:

IP No.

DOA

Consultant Name Room No. : CCV,

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REQUISITION FOR MEDICINE MI. ANANTHA KRISHNAN.P.N

Name of Patient

79/Malc/MH1202381290

Age / Sex

15/12/2023/IPH202302516

Dr.K.JAISHANKAR

Consultant Name Industrial Management Manage

IP No.

DOA

UHID No. :

Room No.: CCい・

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Where heart beat never stops...

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

REQUISITION FOR MENICINE | Mr. ANANTHA KRISHNAN.P.N

Name of Patient

Consultant Name

79/Malc/MHI202381290

Age / Sex

15/12/2023/IPH202302516

Dr.K.JAISHANKAR

IP No.

DOA

UHID No.:

Room No.:

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Where heart beat never stops...

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

REQUISITION FOR MEDICINE

Name of Patient

MI.ANANTHA KRISHNAN.P.N 79/Malc/MHI202381290

Age / Sex

15/12/2023/IPH202302516

Consultant Name

Dr.K.JAISHANKAR IP No. DOA

UHID No.:

Room No.: CCU,

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ಕ ⊯0.	Date	Medicine Name	Qty.
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Nurse Name



(A Unit of United Alliance Healthcare Pvt Ltd)







Where heart beat never stops...

REQUISITION FOR

Mr.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290

Name of Patient

Consultant Name

15/12/2023/IPH202302516

Age / Sex

Dr.K.Jaishankar

IP No.

DOA

UHID No.:

Room No.: ぐけ

S.No.	Date	Medicine Name	Qty.
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Nurse Name

STENDERS ? UTI CCF.





Mr.ANANTHA KRISHNAN.P.N 79/Male/MHi202381290 15/12/2023/iPH202302516 Dr.K.JAISHANKAR

Medway Heart Institute

INTERMEDIATE CARE FLOWCHART

В

NAME: No. frontha Lowshoon. UHID NO: DOBZ 9/29 DAGE: 79 yell - SEX: Nobl.

BLOOD GROUP: 'O' Postin Q.

HEIGHT : $\overline{\mathcal{F}}$ / PB \mathcal{M}

WEIGHT: 160kg

B.S.A: 1 ≈ m2

HAEMODYNAMICS RESP. PARAMETERS INVESTIGATIONS / OTHER DATA TEMP H.R. RHY. ST. B.P. R.A.P. PERI. BREATH SPO₂ 61 linus 98.4 onflor 86 99 wam. Brld 96 D BAM deam Bylu 54 grup 98.4 96 o wharp Qid. 40

PREVIOUS DAY - HOURS 24 VAUND -

DRAINAGE

TOTAL INTAKE 980 M 1.

URINE 1250 M1.

TOTAL OUTPUT (250 m)

BALANCE 270M1







В

NAME: W/M AWARTON KOWSLUVON.

UHID NO: 80888096AGE: 7948. SEX: NOW.

BLOOD GROUP: O' POSTINO .

HEIGHT: 7 168 CM

WEIGHT: \$ 60 kg.

B.S.A: 1-7 m2

												<u> </u>
			HA_	EMOD	YNAN	IICS	•		RES	P. PARAMET	ERS	INVESTIGATIONS /
	TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA
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DRAINAGE URINE

5

PREVIOUS DAY - HOURS

TOTAL INTAKE

TOTAL OUTPUT

BALANCE

TI L.CCF







INTERMEDIATE CARE FLOWCHART

В

. name: Mey. Arartha keilshoan.

UHID NO : 2012812 90 AGE : 79 488 SE

SEX: NOLD

BLOOD GROUP: \ O \ POSTINO

HEIGHT: 1/68 am

WEIGHT: 160kg

B.S.A: 1.7 M

	<u>.</u>	-108 (A	(1)			.2	- BUKU				17/12/23 ->
		НА	EMOD	YNAM	ics	•		RES	P. PARAMET	TERS	INVESTIGATIONS /
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA
7-30	Fy	Sirus	98.49	20/53	#8	konm	++	32	Botch	94%	PHON FM WYB 211-02.
Q.30	76	Sinus	986	128	74	Lam	1+	34	Botci	95 y.	(1
9-30	80	STALS	984		49	AxaTM	1++	<i>3</i> 2	osdel	947	DhRA
10.90	89	kinu	98.	24 52		Larm	Ff	30	1200/1	934.	<i>,</i>
11-30	10	ginus	018-2ª	149	76	Mari	1 H	30	Mcl	947	٨
12-30	72	Engl	98Fr		81	Harm	++	34	Bolci	94%	C,
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(400	75	Sim	974	15%	96	Han	44	8	Brle	981	Or for O2 2 Ilit.
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19.00		Sim	١_	6	Q2	han	144	28	Brlu	92%	٠,
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<u>aj''vo</u>	ba	Sint	98¢			Medil	++	1 7	8 (c)	99-1-	ŧı
gg :a	70	Sand	98f	P2 1017	85	www	+4	gr	Brlc1	981.	71
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PREVIOUS DAY - HOURS $\% \psi \sim \% \%$

DRAINAGE

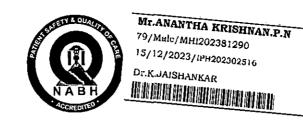
URINE 168011

TOTAL INTAKE 1057 M

TOTAL OUTPUT 1680 M1

BALANCE 523 MI







В

· MAH. Aroutha Kaishran

UHID NO : 20288/129/AGE : FOR YOUR : SEX : NOLL

BLOOD GROUP: 'O' POSTINE

HEIGHT: ±168 CM

MEIGHT: 7 POKO

B.S.A: 1.7 M2

17/12/28-14)

	TEMP H.R. RHY 60.00 & & & & & & & & & & & & & & & & & &		EMOD	YNAM	ics	•		RESI	P. PARAMET	ERS	INVESTIGATIONS /
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA
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DRAINAGE (

PREVIOUS DAY - HOURS

TOTAL INTAKE

TOTAL OUTPUT

BALANCE

s / 2011 / cep







Mr.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290

15/12/2023/IPH202302516

ERMEDIATE CARE FLOWCHART

NAME Dr.K.JAISHANKAR

UHID NO: AGE: 202302516

HEIGHT: Albor

WEIGHT: £60 К 9.

B.S.A: 1. 7m2

			EMOD	VNAM	IICS			PEG	P. PARAMET	TERS	
TEMP	H.R.					PERI.	P.P.	RR	BREATH	SPO2	INVESTIGATIONS / OTHER DATA
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lo 100		Fnw	98'y	112	73	lvaum	++	19	Вии	99+))
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93.00 99.00	-68	linie	08, E	128	81	man	1++	28	Bylel	971	, u

PREVIOUS DAY - HOURS 20 / 73 -

DRAINAGE

TOTAL INTAKE \$684 M

TOTAL OUTPUT

BALANCE => 1816ml

URINE = > 2500 m.







Mr.Anantha krishnan.p.n

79/Malc/MH1202381290

15/12/2023/IPH202302516

Dr.K.JAISHANKAR

UHID NO:

AGE: 키여🎾

202302516

RMEDIATE CARE FLOWCHART

BLOOD GROUP: O PUSITIVE .

HEIGHT: ± 168

NAME:

WEIGHT: ±60

B.S.A: 1 7m2

1/5/12/23 -02 **HAEMODYNAMICS RESP. PARAMETERS INVESTIGATIONS /** OTHER DATA B.P. R.A.P. PERI. BREATH SPO₂ P.P. TEMP H.R. RHY. ST. RR On hoom oul 1 962 Bhol * 25 99% 96) 25 WALK 94% 44 MYPW 21

> DRAINAGE URINE

PREVIOUS DAY - HOURS

TOTAL INTAKE

TOTAL OUTPUT

BALANCE

HORTIC STENOVIS / ? UTI / CCF







INTERMEDIATE CARE FLOWCHART

NAME: MR. ANOWIHA KRISHNAN.

uhid no : 202881290age : 79

SEX:W),

BLOOD GROUP: O' POSITIVE

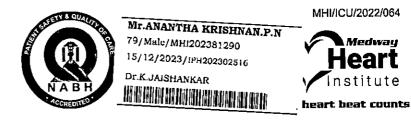
HEIGHT: ± 168 CM WEIGHT: ± 60 Kg B.S.A: 4.7M2

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		HA	EMOE	YNAM	ICS	,		RESI	P. PARAMET	TERS	INVESTIGATIONS /
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA
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13-15	J.	Sins	98.1	F43	92	Wan	44	24	Bld.	96.1	/c
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900	82	Sim	97.1			houn	#4	এ চ	Bulcu	761,	L
0001	83	Sins	942	135	86	atin	++	23	Blo	98	r '
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200	70	G. rug	a4.7	124	81.	nother	44	281	BAd	99%	n
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•				O Z				PI	REVIOUS DAY		3
						AINAGE				TOTAL	- INTAKE
					URI	NE).	`		TOTAL	OUTPUT

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BALANCE







NAME: NA Avortra Kuillman . UHID NO: 2082/296 AGE: 79 you SEX: Noll.

SURGICAL PROCEDURE:

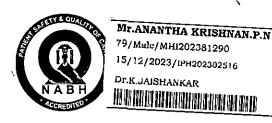
POSTOP DAY:

FLUID REQUIREMENT: 1 to 1.5 liters lday

I.V. FLUIDS ORAL/ R.T. URINE **CHEST DRAINAGE** TOTAL TOTAL **TOTAL** & TIME INTEKE BALANCE **OUTPUT** H.T. G.T. H.T. G.T. **LEAK** 8.00 ĝο 110 30 110' 30 30 9.00 80 190 150 180 230 190 10.00 80 230 90 280 280 SPECIFIC OBSERVATIONS/REMARKS **MEDICATION / DRUGS**

STENDS







INTERMEDIATE CARE FLOWCHART

NAME: War Frantis Knighaan .

UHID NO: 8088/290 AGE: FOR YOUL - SEX: HOLD -

SURGICAL PROCEDURE: -

POSTOP DAY:

FLUID REQUIREMENT: 1 to 1.5 liters lay

													17	10/2	ع	
	DATE	UR	INE	CI	HEST D	RAIN	AGE	TOTAL		I.V. FL	.UIDS			./ R.T.		
	& TIME	н.т.	G.T.		AIR LEAK	н.т.	G.T.	OUTPUT	oppany TeA	ر ا		H.T.	н.т.	G.T.	INTEKE	TOTAL BALANCE
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	SPEC	IFIC OF	BSERVA	TIONS	/REMAR	KS			MEDI	CATION	/ DRUC	SS				
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JULY PF: 3DA OPCIBECT: ON DIHU 19 PROCESSED AGE: 79 YEAR SEX: Nala

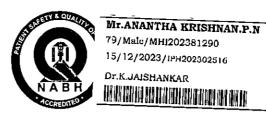
SURGICAL PROCEDURE:

POSTOP DAY : \mathcal{D}^{ϱ} .

FLUID REQUIREMENT: 1 to 1.5 liters lay

														1.4115	1035 -
DATE	UR	INE	Cŀ	IEST D	RAIN	AGE	TOTAL		I.V. FI	UIDS		ORAI	⊥/ R.T.	TOTAL	TOTAL
& TIME	н.т.	G.T.		AIR LEAK	H.T.	G.T.	ООТРОТ				н.т.	н.т.	G.T.	INTEKE	BALANCE
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9-30	70	175				-	175					_	150	lso	25
10-30	F5	250					250					_	150	ιsp	100
11-30	50	300				=. <u>.</u>	300					-	lso	120	150
12-30	50	350	_			_	350.					-	130	150.	200
1300	50	460					400					100	J50	250	1501
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SPEC	IFIC O	BSERVA	TIONS/	REMAR	KS	<u></u>		MEDI	CATION	/ DRUG	SS				
	·				£		>								







STENDOSIS

. 19.9 nordina saturan P. 19.

UHID NO: 2028/290 AGE: 79 yes SEX: NOD

SURGICAL PROCEDURE:

POSTOP DAY : $\mathcal{D}_{\mathcal{I}}$

FLUID REQUIREMENT: 1 to 1.5 liters low

1		T		IFOT F			1		IV E	LUIDS		ОВА	_/ R.T.	14/10/	19.5
DATE & TIME	UR H.T.	G.T.	CH	AIR LEAK	H.T.	G.T.	TOTAL OUTPUT	Tong.		פחוס	H.T.	H.T.	G.T.	TOTAL INTEKE	TOTAL BALANCE
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03.XD	50	1480					1480	_,				100	bso	857	- 522
04:00		1530					1530					-	650	957	- 573
05:50	50	1380					1580					_	650		
Opta	B	1930					OSdl					_	650		_ 673
07/io	Ö2	OBJI					. 08dl					(90)	750	1057	- b23
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SPEC	IFIC O	BSERVAT	rions/	REMAR	KS		1	MEDI	CATION	I / DRU(3S	<u> </u>			
					,										







Mr.Anantha Krishnan.p.n

79/Malc/MHI202381290

15/12/2023/IPH202302516

Dr.K.JAISHANKAR

RMEDIATE CARE FLOWCHART

UHID NO:

AGE:

SEX: M 794

NAME:

SURGICAL PROCEDURE:

2023025/6

FLUID REQUIREMENT: (-1.5 L) day

POSTO	P DA	Y:					FLUI	D REQ	UIREM	ENT:	1-1	·5L	100	щ		
_						_							(237	(
DATE &	UR	INE	CI	HEST C	RAIN	AGE	TOTAL		1 .	LUIDS		ORAI	⊥/ R.T.	TOTAL	TOTAL	
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Mr.Anantha Krishnan.p.n

79/Mulc/MHI202381290 15/12/2023/IPH202302516

RMEDIATE CARE FLOWCHART

Dr.K.JAISHANKAR

NAME:

UHID NO:

AGE: 797 SEX :

202302516

SURGICAL PROCEDURE:

POSTOP DAY:

FLUID REQUIREMENT: 1-1.5 (day

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NAME:

MT.ANANTHA KRISHNAN.P.N

79/Malc/MHI202381290

SURGICAL PR

15/12/2023/IPH202302516

Dr.K.JAISHANKAR

POSTOP DAY :

UHID NO: ๑๑๑๑๑๑๑๑ AGE: 千9

SEX: M

FLUID REQUIREMENT: 1-1.5 Litals day

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