

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



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P Mr. VENKATRAMAN SUBRAMAN  
N 68/Male/MHI202400005  
U 07/01/2024/IPH2024000053  
D Dr. K. JAISHANKAR  
C

MHI/IPD/2022/002



Every heart beat counts

## ADMISSION SLIP

Admitting Doctor: Dr. Jaishankar. 12

Speciality: Cardiology

Advised Date & Time: 07/01/2024 - 7-38 pm

Provisional Diagnosis:

Atrial flutter with varying block / CAD-Mild  
LV dysfunction

Reason for Admission: ☐ Medical Management ☒ Surgical Management  
☐ Others (please specify details)

Admission Type: ☐ Day Care ☐ ER ☒ Ward  
☐ ICU (Specify details)

Surgery / Procedure Name (if planned):

EPS + RF Study

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

Expected Duration of Stay:

3 Days

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

Payer: ☒ Self ☐ Insurance ☐ Others:

Instructions to Nurse (if any):

- NP o from 4am  
- Consent

Any other Instructions (if any):

Doctor's Signature

Name

Reg. No.

Date

Time

Dr. JAISHANKAR

49448

7/1/24 2000

For admission desk staff only:

Room Category: ☐ General Ward

☒ Single Room

☐ Twin Sharing

☐ Deluxe Room

☐ Suite Room

☐ Others \_\_\_\_\_

Admission intimation Receipt Details

Admission Time in HIS

Date

Time

Date

Time

07/01/2024

7.38

07/01/2024

7.38

Source: ☐ OPD

☐ ER

☒ Direct

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

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

Front office Staff Signature

Name

Emp. No.

Date

Time



Aksh.

0169

07/1/23

7.38

## ADMISSION FORM

Marital Status <u>M</u>	Full Address <u>No 1, SWARNA LAKSHMI APTS, LAKSHMIPURAM FIRST STREET, ROYAPETTAH, CHENNAI - 600014</u>	Telephone Number <u>9820520328</u>
Occupation <u>114</u>		
Referred from <u>Dr. Jaishankar</u>	Date of Time of Admission <u>07/01/2024/7.38</u>	Date & Time of Discharge <u>9/1/24 at 17.20</u>
UNIT <u>Cardiology</u>	Total No. of Days <u>3 day</u>	
MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes AR No. :		

FINAL DIAGNOSIS		ICD Code
<u>ATRIAL FLUTTER WITH VARYING</u>		<u>T48.3</u>
<u>BLOCK MODERATE LV DYSFUNCTION</u>		<u>I50.1</u>
<u>EF - 37%. S/P PTCA TO LAD - (2008)</u>		
<u>S/P PTCA TO LEX &amp; RCA (2008) S/P CABG</u>		
<u>(SVC TO LAD &amp; PDA) - APOLLO HOSPITAL</u>		
<u>30/11/22 S/P STERNAL WIRE REMOVAL &amp;</u>		
<u>WOUND DEBRIDEMENT (9.7.22)</u>		<u>T81.3</u>
DATE	OPERATION / PROCEDURES	ICPM Code
<u>8/1/24</u>	<u>CORONARY ANGIOGRAM DONE ON 8/1/24</u>	<u>88.50</u>
	<u>NATIVE TRIPLE VESSEL DISEASE, PATENT</u>	
	<u>SUCH GRAFTS TO LAD &amp; PDA, PATENT STENT</u>	<u>04.3</u>
	<u>SUCCESSFUL ELECTROPHYSIOLOGY STUDY &amp;</u>	
	<u>RADIOFREQUENCY ABLATION</u>	
DATE	TYPE OF ANESTHESIA	

<u>8/1/24</u>	<input type="checkbox"/> GENERAL <input type="checkbox"/> SPINAL <input checked="" type="checkbox"/> LOCAL <input type="checkbox"/> REGIONAL <input type="checkbox"/> EPIDURAL
---------------	--

DISCHARGE STATUS		
<input type="checkbox"/> Cured	<input type="checkbox"/> Discharge at Request	<input type="checkbox"/> Expired < 48 hours
<input checked="" type="checkbox"/> Improved	<input type="checkbox"/> Against Medical Advice	<input type="checkbox"/> Expired > 48 hours
<input type="checkbox"/> Unchanged	<input type="checkbox"/> Absconded	<input type="checkbox"/> Post-Operative Death
<input type="checkbox"/> Transferred to .....		

Signature of the Consultant <u>Dr. K. Jaishankar</u>	Signature of Medical Records Officer <u>S. Alen Jay 2028</u>
---	---

## AUTHORISATION FOR TREATMENT I PAYMENT

I hereby authorise the Administration, Medical and Nursing and Paramedical, Staff of the Hospital Investigate treat and administer such drugs as may be necessary and to perform such operation under anaesthesia or other wise as may be deemed necessary and / or advisable in the diagnosis and treatment of my illness / patient.....Mr. Venkatesh Raman who is my .....Father..... (Relationship).

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

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

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

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

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

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

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

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கப்பட்டிருக்கிறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

  
செவிலியர் கையொப்பம்

Signature of Admitting Nurse

தேதி 07/01/2024

Date

7.38

எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of the Patient / Relative / Gurdian



Son

உறவுமுறை

Nature of Relationship

## GENERAL CONSENT FOR ADMISSION



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

☐ Read

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

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

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

	Signature / Thumb Impression*	Name	Date	Time
Patient			07/11/24	07-38
Surrogate/Guardian (if applicable #)		Son (Write name and relationship with patient)	07/11/24	07-38
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		M. Davila	07/11/2024	07.38
Interpreter (if applicable)				

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



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## DISCHARGE SUMMARY

IP No. : IPH2024000053  
UHID : MHI202400005  
Name : Mr. VENKATRAMAN SUBRMANIAM  
Age / Gender : 68Years / MALE  
Consultant : Dr. JAISHANKAR.K MD., DM., FIAMS  
Director and Clinical Lead  
Cardiology and Electrophysiology

D.O.A : 07/01/2024  
D.O.P : 08/01/2024  
Room No. : 103  
D.O.D : 09/01/2024

### DIAGNOSIS:

ATRIAL FLUTTER WITH VARYING BLOCK

MODERATE LV DYSFUNCTION, EF – 37%

S/P PTCA TO LAD – (2005)

S/P PTCA TO LCX & RCA – (2008)

S/P CABG (SVG TO LAD & PDA) – APOLLO HOSPITAL, 30.04.2022

S/P STERNAL WIRE REMOVAL + WOUND DEBRIDEMENT (09.07.2022 - APOLLO HOSPITAL

SYSTEMIC HYPERTENSION

TYPE II DIABETES MELLITUS

IPH

### PROCEDURE:

1. CORONARY ANGIOGRAM DONE ON 08.01.2024 – NATIVE TRIPLE VESSEL DISEASE, PATENT SVG GRAFTS TO LAD & PDA, PATENT LAD STENT, ISR OF LCX & RCA STENTS.
2. SUCCESSFUL ELECTROPHYSIOLOGY STUDY + RADIOFREQUENCY ABLATION USING 3D ENSITE FOR TYPICAL ATRIAL FLUTTER WITH COUNTER CLOCK WISE DONE ON 08.01.2024.

### BRIEF HISTORY:

Mr. Venkatraman Subrmaniam, 68 years/male, Presented with complaints of palpitation on & off since 4 months. He was referred to Medway heart institute on 02.01.2024, evaluated in OPD and diagnosed as atrial flutter with varying block. He was advised for Coronary angiogram + Electrophysiology study + radiofrequency ablation using 3D ensite for which he has been admitted.

No H/O fever, cough, vomiting, diarrhea.

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

N/K/C/O RHD / CKD, BA, seizure disorder or Hypothyroidism.

### ALLERGY: Penicillin

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#### Medway Centre of Excellence (Chennai)

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





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NAME: MR. VENKATRAMAN SUBRAMANIAM

UHID: MHI202381499



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### ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

HR - 104bpm  
BP - 120/80mmHg  
SPO<sub>2</sub> - 96% in room air  
CVS - S1S2 (+)  
RS - BAE (+)  
Abdomen - Soft  
CNS - NFND

### INVESTIGATIONS:

**BLOOD(04.01.2024)** : Hb - 13.0gm/dl, TC- 7410cells/cumm, PLT - 188000laks/cumm, Urea - 36mg/dl, Creatinine- 1.10mg/dl, Na+ - 135mmol/l, K+- 4.65 mmol/l, INR - 0.9.

**ECG**: Atrial Flutter with varying conduction block (1:1, 2:1, 3:1) rate @ 114BPM.

**CXR**: No cardiomegaly, BVM+, B/L lung fields clear.

**SCREENING ECHO(04.01.2024)**: S/P PTCA + CABG. All chambers normal sized. Paradoxical septum. Global hypokinesia. Moderate LV systolic dysfunction. EF - 37%. Indeterminate diastolic function. Mild RV systolic dysfunction. IAS /IVS intact. Aortic valve sclerosis. No AS /AR. Other valves are structurally normal. Mild MR. Trivial TR, Moderate PAH. IVC normal in size and collapsing. No clot / vegetation / effusion.

### POST RFA INVESTIGATIONS:

**ECG**: normal sinus rhythm, HR - 64bpm.

**SCREENING ECHO (08.01.2024)**: S/P PTCA + CABG + RFA. Dilated atria. Global hypokinesia. Moderate LV systolic dysfunction. EF - 38%. Normal RV systolic function. Indeterminate diastolic function. Aortic valve sclerosis. Other valves are normal. IAS /IVS intact. Mild MR. Mild TR. Mild PAH. No clot vegetation / effusion.

### COURSE IN THE HOSPITAL:

Mr. Venkatraman Subramaniam, 68 years/male, was admitted with above mentioned complaints. Basic investigation was done. He underwent Coronary Angiogram by Right radial access which revealed Native Triple Vessel Disease, Patent SVG grafts to LAD & PDA, patent LAD stent, ISR of LCX & RCA stents followed by **SUCCESSFUL ELECTROPHYSIOLOGY STUDY + RADIOFREQUENCY ABLATION USING 3D ENSITE FOR TYPICAL ATRIAL FLUTTER WITH COUNTER CLOCK WISE DONE ON 08.01.2024.** His post procedure period was uneventful and shifted to CCU. Right femoral access site normal, peripheral pulses well felt, no hematoma/soakage. Post RFA ECG showed normal sinus rhythm and ECHO showed no pericardial effusion. He was observed in ICU and shifted to ward. His medications are optimized and he is being discharged in a stable clinical condition.

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NAME: MR. VENKATARAMAN SUBRMANIAM

UHID: MHI202381499



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**CONDITION ON DISCHARGE:**

Patient Conscious / Oriented / Afebrile

General condition Stable

GCS - 15/15

Temp - 98.6°F

PR - 62/min

BP - 120/80mmHg

SPO2 - 96% in room air

**ADVICE MEDICATIONS:**

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH MEAL	DURATION
			M	A	N			
1.	TAB. DEPLATT (CLOPIDOGREL)	75 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
2.	TAB. ELIQUIS (APIXABAN)	2.5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
3.	TAB. ROZAVEL (ROSUVASTATIN)	20MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4.	TAB. LASILACTONE (SPIRONOLACTONE, FRUSEMIDE)	20/50M G	½	0	0	ORAL	AFTER FOOD	TO CONTINUE
5.	TAB. SELOKEN XL (METOPROLOL SUCCINATE)	25 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
6.	TAB. CORDARONE (AMIODARONE)	200 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
7.	TAB. FLAVEDON MR (TRIMETAZIDINE)	35 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
8.	TAB. NITROCONTIN (NITROGLYCERIN)	2.6 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
9.	CAP. BECOSULES	1 TAB	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
10.	TAB. URIMAX - D (TAMSULOSIN + DUTASTERIDE)	1 TAB	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
11.	TAB. LIVOGEN (FERROUS FUMARATE AND FOLIC ACID)	1 TAB	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
12.	TAB. PAN (PANTOPRAZOLE)	40 MG	1	0	0	ORAL	BEFORE FOOD	TO CONTINUE
13.	TAB. CREMALAX	1 TAB	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
14.	TAB. ALPRAX (ALPRAZOLAM)	0.25 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
15.	TAB. DOLO (PARACETAMOL)	650 MG	1	1	1	ORAL	AFTER FOOD	X 3 DAYS

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Heart Institute  
044 - 4310 8959

Institute of Pulmonology  
044-2473 4451

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NAME: MR. VENKAT RAMAN SUBRMANIAM

UHID: MHI202381499



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**DIABETIC MEDICATIONS:**

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH MEAL	DURATION
			M	A	N			
1	TAB. XIGDUO XR	10/500 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. JANUVIA	100 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. AMARYL M1	1 TAB	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
4	TAB. GLUCOBAY	50 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
5	INJ. HUMALOG	25 MG	16 U	0	20 U	S/C	BEFORE FOOD	TO CONTINUE

**DISCHARGE ADVICE**

<b>DIET</b>	LOW FAT, SALT & DIABETIC DIET.
<b>PHYSICAL ACTIVITIES</b>	DAILY WALKING FOR 30 MINS.
<b>REVIEW</b>	REVIEW WITH DR. JAISHANKAR. K AFTER 1 MONTH WITH ECG.

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

"I understood the Content of the discharge summary."

*[Signature]*

Typed by: Ezhilarasi  
"I understood the Content of the discharge summary."

*[Signature]*  
**CONSULTANT SIGNATURE**

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

**Dr. K. JAISHANKAR**  
Reg. No: 49448

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

**Medway Centre of Excellence (Chennai)**

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

## CONSENT FORM FOR CRITICAL CARE (ICU)

I, Mr. Venkatesh Subraman the ☒ Patient or ☐ Representative of patient have (please tick the correct option above and below):

☐ Read

☒ I 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.

☒ I have 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
- Arrhythmia
- 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 re inflated by placing a tube between the ribs to remove the air that has leaked from the lung.

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

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

**Alternative Forms of Treatment:** Peripheral Venous Access

## ENDOTRACHEAL INTUBATION

### Brief description of the Procedure:

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

The size of the breathing tube is matched to the age and throat size. The tube is kept in place by a small cuff of air that inflates around the tube after it is inserted. The trachea begins just below the larynx, or voice box, and extends down behind the breastbone, or sternum. Trachea then divides and becomes two smaller tubes: the right and left main bronchi. Each tube connects to one of the lungs. The bronchi then continue to divide into smaller and smaller air passages within the lung. The trachea is made up of tough cartilage, muscle, and connective tissue. Its lining is composed of smooth tissue. Each time you / your patient breathes in, the 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): \_\_\_\_\_

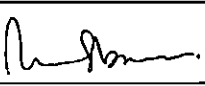

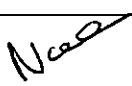
### Possible alternatives:

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 procedure and recovery, few cases may be associated with complications. I am aware of the common risks and complications associated with this procedure as listed above, and understand that it is not possible to list all possible risks and complications of any procedure.


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

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

	Signature / Thumb Impression*	Name	Date	Time
Patient				
Surrogate/Guardian (if applicable #)		 (WIFE <small>(Write name and relationship with patient)</small> )	8/1/24	13:15
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		E. Nalini	8/1/24	13:15
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		Dr. G. Alister	91810	8/1/24	13:15

## உயிரகாப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

என்ற பெயர் கொண்ட ட நோயாளியான அல்லது ட நோயாளியின் பிரதிநிதியான நான், இந்த ஒத்திசைவு படிவத்தை (மேலே மற்றும் கீழே உள்ளவற்றில் சரியான விருப்பத்தேர்வை தயவுசெய்து டிக் செய்க)

☐ வாசித்திருக்கிறேன்

ட சிகிச்சையளிக்கும் மருத்துவரால் எனக்கு வீளக்கி கூறப்பட்டிருக்கிறது மற்றும் எனது / எனது நோயாளியின் தற்போதைய நிலைமை அல்லது எனது நோயாளியின் நோய் பாதிப்பையும் மற்றும் ஏற்பட சாத்தியமுள்ள அனைத்து விளைவுகளையும் நான் அறிந்திருக்கிறேன் மற்றும் புரிந்து கொண்டிருக்கிறேன்.

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

எனது அல்லது எனது நோயாளியின் உடல்நிலை, சிகிச்சை விருப்பத்தேர்வுகள், நோயாளியின் நிலையை மேம்படுத்துவதற்கு தேவைப்படும் மருத்துவ சேவைகள் பற்றி 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 முக்கப் பெருங்குழல்களுக்கு குழாய் செருக்தல் போன்ற அவசரநிலை மருத்துவ செயல்முறைகளை செய்யவும் இதன்வழியாக நான் ஒப்புதல் அளிக்கிறேன். மேலும் எனது நிலைமைக்கு சிகிச்சையளிக்க அல்லது அதனை மேம்படுத்த தேவைப்படும் கண்காணிப்பு வழிமுறைகளை மேற்கொள்ளவும் ஒப்புதல் அளிக்கிறேன்.

### மைய சிரையில் கதிட்டர் உட்செருகல்

மருத்துவ செயல்முறையின் சுருக்க விவரணை:

ஒரு மைய சிரை கதிட்டர் 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 எடுத்துக்காட்டுகளாகும்.
- 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 தீர்மானிக்க இது உதவக்கூடும்.
- பரிசோதனையகத்திற்கு அடிக்கடி இரத்த மாதிரிகளை அனுப்ப வேண்டிய தேவையுள்ள நோயாளிகளுக்கு திரும்பத்திரும்ப நோயாளிக்கு உசிசுத்தி 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 வாசோபிரெசர்ஸ் - ஐ வழங்குவது சிறிய இரத்த நாளங்களுக்கு சேதத்தை விளைவிக்கும் என்பதால், அதிர்ச்சியில் ஆழ்ந்துள்ள ஒரு நோயாளிக்கு வாசோபிரெசர்ஸ்களை (இரத்த அழுத்தத்தை அதிகரிப்பதற்கான மருந்துகள்) வழங்குவதற்கு.
- சில நேர்வுகளில், டயலாலிசிஸ் செய்வதற்கு மைய லைன் மீது இரண்டு குழல்களைப் பயன்படுத்தலாம். இரத்தநாள அமைப்பிலிருந்து இரத்தத்தை எடுப்பதற்கு ஒரு குழலையும், டயலாலிசிஸ் செய்யப்பட்ட இரத்தத்தை உடலுக்கு திரும்ப அனுப்புவதற்கு மற்றொரு குழலையும் பயன்படுத்தலாம்.

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

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

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

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

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அணுகுவசதி

## முச்சப் பெருங்குழலுள் குழாய் செருகுதல்

மருத்துவ செயல்முறையின் கருக்கமான விவரணை:

முச்சப் பெருங்குழலுள் குழாய் செருகுதல் (Endotracheal Intubation) என்பது, தாங்களே சுயமாக சுவாசிக்க இயலாத அல்லது நினைவழிந்துவிட்ட நபர்களுக்கு செய்யப்படும் ஒரு அவசரநிலை சிகிச்சை செயல்முறையாகும். இது, ஒரு திறந்தநிலை முச்சப்பாதையை பராமரிக்க வகை செய்கிறது மற்றும் முச்சத்தினால் நிகழாமல் தடுக்கிறது. நீங்கள் சுவாசிப்பதற்கு உதவு, உங்களது / உங்களது நோயாளியின் முச்சக்குழலுக்குள் ஒரு நெகிழ்வத்தின் கொண்ட பிளாஸ்டிக் குழாய் வாய் வழியாகப் பொருத்தப்படுகிறது. முச்சக்குழாய் என்றும் அழைக்கப்படுகின்ற இந்த முச்சக்குழாய், ஆக்சிஜனை நுரையீரல்களுக்கு எடுத்துச்செல்லும் ஒரு குழாயாகும். சுவாசிப்பதற்கான 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. முச்சக்குழாய், குரல்வலைக்கு சற்றுக்கீழே தொடங்குகிறது மற்றும் மார்பு எலும்பிற்கு பின்னே வரை அது நீள்கிறது. அதன்பிறகு முச்சக்குழாய் இரு சிறு குழல்களாக பிரிகிறது: வலது மற்றும் இடது பிரதான முச்ச சிறுகுழாய்கள் ஒவ்வொரு சிறுகுழாயும், ஒவ்வொரு நுரையீரலோடு இணைக்கப்பட்டிருக்கிறது. இந்த முச்ச சிறுகுழாய், அதன்பிறகு நுரையீரலுக்குள் சிறு சிறு காற்றுப் பாதைகளாக தொடர்ந்து பிரிகின்றன. முச்சக்குழாய் என்பது, கடினமான குருத்தெலும்பு, தசை மற்றும் இணைப்புத்திசு ஆகியவற்றால் உருவானது. இதன் அகவுறை மிருதுவான திசுக்களால் ஆனது. ஒவ்வொரு முறையும் நீங்கள் / உங்களது நோயாளி காற்றை உள்ளே சுவாசிக்கும்போது முச்சக்குழாய் சற்றே நளமானதாக மற்றும் விரிவானதாக ஆகிறது. முச்சை வெளியே விடும்போது அதன் முந்தைய தளவான நிலைக்கு அது திரும்புகிறது. முச்சப்பாதையில் எந்தவொரு இடமும் சேதமடைந்திருக்குமானால் அல்லது தடை பட்டிருக்குமானால் உங்களால் சுவாசிக்க இயலாமல் போகலாம் அல்லது சுவாசிப்பதில் சிரமம் இருக்கலாம். இத்தகைய தருணத்தில் தான் முச்சப் பெருங்குழலுள் குழாய் செருகுதல் அவசியமாக இருக்கக்கூடும். இந்த செயல்முறை உங்களது முச்ச / காற்றுப்பாதையை அடைப்பின்றி திறந்த நிலையில் வைக்கிறது. நீங்கள் சுவாசிக்கும்போது உங்களது நுரையீரலிலிருந்து மற்றும் நுரையீரலுக்கு ஆக்சிஜன் தடையின்றி, தாராளமாக சென்று வருவதை இது அனுமதிக்கிறது.

**அடையத் திட்டமிடப்பட்டுள்ள பலன்கள்:**

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

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

**சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:**

- பற்கள் அல்லது பற்கட்டமைப்பிற்கு காயம்
- தொண்டை அல்லது முச்சக்குழாயில் காயம்
- இரத்தக்கசிவு
- நுரையீரல் சிக்கல்கள் அல்லது காயம்
- உறிஞ்சி வெளியீடுதல் (வயிற்றிலுள்ள உணவுப்பொருட்களும், அமிலங்களும் நுரையீரல்களில் சேர்ந்திருக்கும்போது)
- பிற இடர்கள் (ஏதும் இருக்குமானால்):

**சாத்தியமுள்ள மாற்று வழிமுறைகள்:**

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

மேற்குறிப்பிடப்பட்ட மருத்துவ செயல்முறையின் மூலம் அடையத் திட்டமிடப்பட்டுள்ள பலன்கள், சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள், இந்த செயல்முறைக்கு கிடைக்கக்கூடிய பிற மாற்று வழிமுறைகள் பற்றி இப்போது நான் அறிந்திருக்கிறேன். எந்தவொரு மருத்துவ செயல்முறையிலும் அதன் முடிவுகள் நோயாளிக்கு நோயாளி வேறுபடக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன்; மற்றும் இந்த மருத்துவ செயல்முறையின் வெற்றி குறித்து எனக்கு எந்தவித உத்தரவாதங்களும் அளிக்கப்படவில்லை என்பதையும் நான் உறுதிப்படுத்திக்கொள்கிறேன். பெரும்பான்மையான நோயாளிகளுக்கு அசம்பாவிதம் இல்லாமல் அறுவைசிகிச்சை மற்றும் மீண்டு குணமடைதல் நிகழ்கின்ற நேரவில், சில நேரவுகளில் சிக்கல்கள் ஏற்படக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன். மேலே குறிப்பிடப்பட்டுள்ள இந்த மருத்துவ செயல்முறையோடு தொடர்புடைய பொதுவான இடர்கள் மற்றும் சிக்கல்களை நான் அறிந்திருக்கிறேன். எந்தவொரு 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 மனநிலை கொண்ட நபராக இருக்கிறேன் மற்றும் எந்தவித அச்சம், அச்சுறுத்தல் அல்லது தவறான கண்ணோட்டம் இல்லாமல் இச்செயல்முறைக்கு ஒப்புதல் அளிக்கிறேன் என்று இதன் மூலம் நான் மேலும் உறுதிமொழியளிக்கிறேன்.

	கையொப்பம் / கட்டைவிரல் ரேகை*	பெயர்	தேதி	நேரம்
நோயாளி				
பதிலாளர் / பாதுகாவலர் (பொருத்தமானால் *)		(பெயர் & நோயாளிக்கு என்ன உறவுமுறை என்பதை எழுதவும்)		
பதிலாளர் ஒப்புதல் வழங்குவதற்கு காரணம்	நோயாளியால் ஒப்புதல் வழங்க இயலவில்லை; ஏனெனில்:			
சாட்சி				
மொழிபெயர்ப்பாளர் (பொருத்தமானால்)				

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

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

	கையொப்பம்	பெயர்	பதிவு எண்.	தேதி	நேரம்
மருத்துவர்					



## INPATIENT INITIAL ASSESSMENT

Date: 7/1/24

Time of arrival in ward: 9:00

Allergies (if Yes, specify details):

Drugs ☒ Yes ☐ No Penicilline

Blood Transfusion ☐ Yes ☒ No

Food ☐ Yes ☒ No

Others

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 104 (beats/min) | BP: 120/80 (mmHg)

Respiration: 20 (breaths/min) | SpO<sub>2</sub>: 96 (%) | Height: 176 (cms) | Weight: 78.6 (kgs) | BMI: 24.9 kg/m<sup>2</sup>

Pain: ☐ Yes ☒ No. If Yes, Score: 0/10

Pain Scale Used: ☒ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)

Duration: Location:

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

### CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

pt. referred to OPD for KPS + RFA flw.  
H/o palpitations on & off 24 months.  
CAD.

### PAST MEDICAL HISTORY (with duration of illness):

Diabetes Mellitus: ☒ Yes ☐ No. If Yes, duration: 14 yrs. Hypertension: ☒ Yes ☐ No. If Yes, duration: 14 yrs.

Others:

K/dob CAD. / BPH CAD - mild LV dysfunction

### Past Surgical History:

8/17 PTCA to LAD - 2005

PTCA to LCX + RCA - 2008.

CABG - 30/4/22. (SVC to LAD + PDA).

Sternal wire removal + wound debridement (9/7/22)



**Present Medication (for Medication Reconciliation):**

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1.	T- SELOKEN XL	200	po	1-0-0	7/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2.	T- DREPLATT A	750	po	0-1-0	"	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3.	T- ROZAVEL	1 tab	po	0-0-1	6/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4.	T- CORDARONE	200	po	0-0-1	"	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5.	T- PAN 400	(B/E) 400	po	1-0-1	7/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6.	T- CREMALAX.	1 tab	po	0-0-1	6/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7.	C- BE COSULES		po	1-0-0	7/1/24	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	T- LABILACTONE		po	1/2-0-0	7/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9.	T- APZEXAN	200		1-0-1	9/1/24	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

**Family History:**

**Personal / Social History (Tick whichever is applicable)**

Lifestyle: ☐ Sedentary ☒ Active Occupation: \_\_\_\_\_  
 Smoking: ☐ Yes ☒ No Alcohol: ☐ Yes ☒ No Recreational Drug Use: ☐ Yes ☐ No  
 Others: \_\_\_\_\_

**Menstrual and Obstetric History (to be filled up for female patients):**

**General Physical Examination:**

Pallor: ☐ Yes ☒ No Icterus: ☐ Yes ☒ No Clubbing: ☐ Yes ☒ No  
 Edema: ☐ Yes ☒ No Lymphadenopathy: ☐ Yes ☒ No

## SYSTEMIC EXAMINATION

CVS:

S1S2 (P), NAS

Respiratory System:

BALE (P), NAS

Gastrointestinal System:

Soft, NFN

Central Nervous System:

Urinary / Reproductive / Locomotor System:

Skin / Ophthalmic / ENT

nothing gross, no heavy leg

Suspected of contagious disease: ☐ Yes ☒ No

Immuno compromised status: ☐ Yes ☒ No

Isolation required:

☐ Yes ☒ No, if yes, ☐ Contact ☐ Airborne ☐ Droplet

Psychological Evaluation:

☒ Normal ☐ Anxious ☐ Depressed ☐ Others: \_\_\_\_\_

Nutritional Screening (ESPEN Guidelines for Nutritional Screening - NRS 2002):

Weight loss within the last 3 months? ☐ Yes ☒ No

Is the patient severely ill? (e.g. in Intensive Therapy) ☐ Yes ☒ No

Reduced dietary intake in the last week? ☐ Yes ☒ No

Is the BMI < 20.5? ☐ Yes ☒ No

Interpretation: Yes: If the answer is "YES" to any 2 questions, the patient is at nutritional risk

No: If the answer is "NO" to all questions, the patient is at Normal and not at risk

Provisional Diagnosis:

CAD / BPH / T2DM / ST-TN / CABG-2022  
ER-384

Plan of Care:

- BP STRA

- vitals monitoring

- Follow up diet

- ulr denture

- Eferm son

**Investigations Advised:***Reports attached***Diet Advice:**

- ☐ Nil per Oral      ☐ Clear liquid diet      ☐ Normal liquid diet      ☐ Diabetic liquid diet  
☐ Semisolid diet      ☐ Soft solid diet      ☐ South Indian normal diet      ☐ North Indian normal diet  
☐ Neutropenic liquid diet      ☐ Others: Dr. Salted

**Early Discharge Planning** (fill in those which are appropriate at this stage):

PFE: Patient Family Education

Special support needed at home	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If Yes, PFE done
Home equipment anticipated	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If Yes, PFE done and equipment advised
Physiotherapy at home anticipated	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If Yes, educated on physical limitations, if any
Wound care needs anticipated at home	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If Yes, educated on signs on infection
Pain Management	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If Yes, PFE done and medication advised
Special Dietary needs	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If Yes, educated on dietary restrictions, food drug interactions and allergies
Continuous / ongoing care anticipated	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If Yes, educated on various aspects of ongoing care required
Other special education need, i.e.:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If Yes, PFE done
Nature of post hospital needs like patient safety, infection control, fall risk, etc, addressed	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If Yes, specific education given

**Others:**

	Signature	Name	Reg. No.	Date	Time
Resident Doctor	<i>[Signature]</i>	Dr. Sujitha B	183573	7/1/24	8.00 PM
Consultant	<i>[Signature]</i>	Dr. Jaishankar	49448	8/1/24	10:10
Patient Attendant	<i>[Signature]</i>	Relationship Son	—	7/1/24	20:00

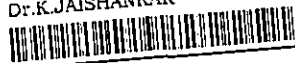
**PRE/POST OPERATIVE ECHO**

Mr. VENKATRAMAN SUBRAMAN

68/Male/MHI202400005

07/01/2024/IPH2024000053

Dr. K. JAISHANKAR



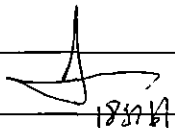
Screening Echo

Date & Time	S/P PTCA + CABG + RFA
08-01-2024	
3:00pm	<ul style="list-style-type: none"> <li>Dilated atri.</li> <li>Global Hypokinesia</li> <li>Moderate LV systolic dysfunction</li> <li>Normal RV systolic function</li> <li>Indeterminate diastolic function</li> <li>Aortic valve sclerosis</li> <li>Other valves are normal.</li> <li>TASI IVC intact</li> <li>Mild MR</li> <li>Mild TR. mild PAH.</li> <li>No clob vegetation/effusion</li> </ul>
	HR during study: 68 bpm
	LA: 43x68mm RA: 48x60mm LV LDD: 53mm LV LDD: 43mm EF: 38%
	MR jet area: 6.2cm <sup>2</sup> TR P4: 30mmHg RVSP: 40mmHg
	Done by: Zibian (PA/RC)
	MHI/0053/AD

## DOCTOR'S PROGRESS NOTES

DATE	NOTES
7/1/24	S/B Dr. Mohamed Hydhoos.
bpm.	Post status CAD / BPH / T2DM / SHTN / CABG (2022) EF - 38% / Atrial flutter with varying block Plan : EPS + RFA Tomorrow.
	Patient conscious oriented Afebrile.
<u>Vitals</u>	
Stable.	CVS → S1S2P RS → BAE (+) P/A → S/L, NT
	Adv. - monitor Vitals
	- To follow day chart
	- NPO from 4 PM
	- Dig. Sulfagreat 1gm IV stat
	Before shifting Cathlab at 8 PM

*(Signature)*  
K. Jaishankar

DATE	NOTES
08/01/24 12:30pm.	CIDB Dr. K. <u>Poishankar</u> .
Catheter 3553/54/55.	<p>Procedure: Coronary Angiogram + Electrophysiology study + Radio frequency ablation with 3D map</p>
	↓ SAP, using 2.1. mepivacaine as local anaesthesia.
	<u>Coronary Angiogram</u>
	LMCA: normal. Bifurcates into LAD + LCX
	LAD - Type I vessel & gives rise to 1 diagonal. Normal. Proximal LAD has luminal irregularities. Mid LAD stent native & Patent. Distal LAD has total occlusion
	LCX - Non dominant & gives rise to 3 ams. Proximal LCX has luminal irregularities. Distal LCX stent native & total occlusion (ISR). ams have luminal irregularities
	RCA - Dominant & gives rise to PDA & PLV branches. Proximal RCA has luminal irregularities. Mid RCA has 80% tubular stenosis. Distal RCA has stent native & total occlusion (ISR)
	



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



MR. VENKATRAMAN SUBRAMAN

68/Male/MHI202400005

07/01/2024/IPH2024000053

Dr.K.JAISHANKAR



MHI/IP/2022/041



**ery heart beat counts**

### DOCTOR'S PROGRESS NOTES

DATE	NOTES
8/1/24 C.O. 4.0	EP Study + RFA with SD cath Patient was <del>present</del> <sup>inpatient</sup> Atrial flutter & start of procedure. Hx - Hx rxn, CS - 8F - HD grid catheter RA & geometry created. Activation, propagation, entrain mapping. Tachycardia defined to be RA AF counts clockwise using catheterized return (CTI) for conduction. Using a TA cath path flex ability Catheter (35, 43, 66-120 S) CTI was targeted for RFA AF terminated during ablation. further consolidation done at same adjoining region. [CTI - b'd TCA]. 2 Bidirectional block was demonstrated by both sides. Post RFA: LRA - CS. (150ms). Differential pacing was done. Post RFA intervals are normal. Final Impression: • Counter clockwise is Typical Atrial Flutter. • Successful ablation done.







Mr. VENKATRAMAN SUBRAMAN  
68/ Malc/ MH1202400005  
07/01/2024/ IPH2024000053  
Dr. K. JAISHANKAR



Medway  
**Heart**  
Institute

**Every heart beat counts**

## DATE \_\_\_\_\_

## NOTES

8 7.624

813 Dr. Hartman

pt reviewed from Cath lab

СЧЗ: 1.5 нм  $\mu$  нр: 65/мм Вр: 100/60

MS: BPT2(-) Spec: 954-205

AIA: 1072

Cons: 1025 cons crited.

Wanted wrap

tolerant and good  
vibes make

Feb

days as directed

No chrt

Memorandum

Or as removed

Immobilization for 8 hrs

Cont. Zurborn

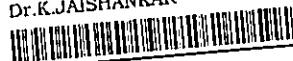
12

8585/

DATE	NOTES
2/1/2024 14:30	9/1/13: Dr. h. Akshun -
	3/1/13: CO <sub>2</sub> + GPS + RFA done today
	HR = 83/min
	BP = 120/65
	RR =
	SpO <sub>2</sub> = 95% JRA
	3/1/13: Can: S.A. ①
	Rs: B600 ①
	Rp: 50ft
	Cm: 10m
	res 205/15
	R.
	- Embrace ① 22
	- w/ft Bleeding / Haematoma
	- dry on per chest
	- 40 chest
	- vitals mainly
	- wound shift every
	9/1/13: Dr. Jaishankar Sr.
	Shift to room
	9/1/13



Dr.K.JAISHANKAR



Medway  
**Heart**  
Institute

**every heart beat counts**

## DATE \_\_\_\_\_

## NOTES

8/1/24,

6-4812

S/B. Dr. Singh B. (Dano)

14. received in ward

8/2 - CAC + EPS + RPA done

1A-series.

- 20 copies

2/18 Attention  
oriented  
speech

$\frac{8}{\pi} - \cos^{-1}(0) = \frac{\pi}{2}$

Ad

- vitalizing
- w/ or w/o therapy/dietary
- Immobilize (P)LL.
- Block
- ~~transfer~~ or

~~183573~~

DATE	NOTES
08/11/24	S/B Dr. Anusuya
22.00	Patient reviewed
	C/O: Generalised tiredness
	D/E: Patient conscious, oriented,
	S/E: CVS - S1, S2 ⊕
	RS - BAE ⊕
	CNS - NFAUD
	P/A - Soft, Non-tender
	Vitals: HR - 82b/m
	BP - 110/80mmHg
	RR - 18/min
	SpO2 - 98% RA
	Advice
	- monitor vitals
	- continue the drugs as per
	chart.
	- mobilize the patient
Kdm 134mm	



\_\_\_\_\_

**counts**

DATE	NOTES
9/1/24 9 AM	9/8 Dr. Garthman's steams PT removed B/A = concave, oriented PR - 62/45, BP - 120/80 SpO2 96% RA Aua = 2/4 ⊕ RA = BAC ⊕ Gruvi → ⊕  Adv - Cant the same - d/c today evening - Review after 1 month  Jmz 9/24



# MICROBIOLOGY SHEET

DATE	11/1/24		
COLOUR	pale yellow		
REACTION			
SPECIFIC GRAVITY	1.005		
APPEARANCE	clear		
ALBUMIN			
SUGAR			
ACETONE			
BILE SALT			
BILE PIGMENT			
UROBILINOGEN	normal		
PUS CELLS	3-5		
EPITHELIAL CELLS	1-2		
RBC	nil		
CASTS	nil		
CRYSTALS	nil		
OTHERS	nil		

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



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Mr. Kigduo KR 10/500 mg too  
Mr. Januvia 100mg too  
Amaryl M1 too



MHI/IP/2022/065



**NAME ALERT**

## DIABETIC CHART

Mr. VENKATRAMAN SUBRAMAN

68/Male/MHI202400005

07/01/2024/IPH2024000053

Dr. K. JAISHANKAR



ACTUAL WEIGHT ..... HbA<sub>1c</sub> ..... 164 - 0 - 20 U. B/F

PREVIOUS DIABETIC MEDICATIONS ..... T. Glucobay 50mg 0-10

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
7/1/24	9:30	159 mg/dl	—	Dr. J. H.	Dr. K. S.
	6:30	111 mg/dl	NPO from 4AM	Dr. J. H.	Dr. K. S.
8/1/24	18:20	157 mg/dl	—	Dr. J. H.	Dr. K. S.
	18:30	200 mg/dl	Inj Humalog 2U	Dr. J. H.	Dr. K. S.
9/1/24	6:30	247 mg/dl	Inj Humalog 2U	Dr. J. H.	Dr. K. S.
	12:30	347 mg/dl	Inj. Humalog 2U Inj. HA 6U	Dr. J. H.	Dr. K. S.

### INSTRUCTIONS FOR INSULIN INFUSIONS

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

Mr. VENKATRAMAN SUBRAMAN

68/Male/MHI202400005

07/01/2024/IPH2024000053

Dr. K. JAISHANKAR



**BLOOD GROUP**

'B' positive

**INVESTIGATION SHEET**

Date	4/1/24					
<b>HAEMATOLOGY</b>						
Hb	13.0					
P.C.V	41.2					
Platelets	183000					
TLC	7410					
Polymorphs	68.9					
Lymphocytes	20.8					
Eosinophils	4.8					
Mono / Basophils	5.1/0.4					
E.S.R						
<b>BIO-CHEMISTRY</b>						
Urea	36					
Creatinine	1.10					
Sodium	135					
Potassium	4.65					
Bicarbonate	23					
Chloride	98					
Magnesium						
Calcium						
Phosphorus						
<b>LFT</b>						
T.Bilirubin						
D.Bilirubin						
I.Bilirubin						
S.G.O.T						
S.G.P.T						
ALP						
GGT						
Total Protien						
S.Albumin						
<b>CARDIAC ENZYMES</b>						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						



[illegible]

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**MR. VENKATRAMAN SUBRAMAN**

68/Malc/MH1202400005

07/01/2024/IPH2024000053

Dr.K.JAISHANKAR



## ALLERGY

penicillare

# VITAL INFORMATION SHEET

MHI/IP/2022/G74



**Every heart beat counts**

BLOOD GROUP *B* " *positive*

**ON ADMISSION**

**Height in CM**

**Weight in Kg.**

176 cm

78.6129

Diagnosis: CAD, BPH, T2DM, SHTA, SLP LAB CG Procedure:

[illegible]

**Medway Hospitals**

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68/Malc/MH1202400005

07/01/2024/IPH2024000053

Dr.K.JAISHANKAR



## VITAL MONITORING CHART

Patient received From CCU at 18.00pm  
Monitor Sauterations.

[illegible]

## EARLY WARNING SCORE MONITORING CHART

Name: \_\_\_\_\_

Age/Sex: \_\_\_\_\_

Patient Id No: \_\_\_\_\_

NEWS key	DATE	TIME	DATE	TIME
0				
1				
2				
3				
A+B				
Respirations				
Breath/ min				
	>25		>25	
	21-24		21-24	
	18-20		18-20	
	15-17		15-17	
	12-14		12-14	
	9-11		9-11	
	<8		<8	
A+B				
SpO2 Scale 1				
Oxygen Saturation (%)				
	>96		>96	
	94-95		94-95	
	92-93		92-93	
	<91		<91	
SpO2 scale 2 oxygen saturation (%) use scale 2 if target range is 98-92 % eg: In hypercapnic respiratory failure only				
	>96 on oxygen		>96 on oxygen	
	95-96 on O2		95-96 on O2	
	93-94 on O2		93-94 on O2	
	>93 on air		>93 on air	
	88-92		88-92	
	86-87		86-87	
	84-85		84-85	
	<83%		<83%	
Air or Oxygen ?				
	A= Air		A= Air	
	O2litre/ min		O2litre/ min	
	Device		Device	
C				
Blood Pressure				
	>220		>220	
	201-219		201-219	
	181-200		181-200	
	161-180		161-180	
	141-160		141-160	
	121-140		121-140	
	111-120		111-120	
	91-100		91-100	
	81-90		81-90	
	71-80		71-80	
	61-70		61-70	
	51-60		51-60	
	<50		<50	
D				
Diastolic BP				
	mmHg		mmHg	
	>131		>131	
	121-130		121-130	
	111-120		111-120	
	101-110		101-110	
	91-100		91-100	
	81-90		81-90	
	71-80		71-80	
	61-70		61-70	
	51-60		51-60	
	41-50		41-50	
	31-40		31-40	
	<30		<30	
D				
Consciousness				
Score for New onset of confusion (no score if chronic)				
	Alert		Alert	
	Confusion		Confusion	
	V		V	
	P		P	
	U		U	
E				
Temperature				
Degree Celsius				
	>39.1 degree Celsius		>39.1 degree Celsius	
	38.1-39.0		38.1-39.0	
	37.1-38.0		37.1-38.0	
	36.1-37.0		36.1-37.0	
	35.1-36.0		35.1-36.0	
	< 35.0		< 35.0	
NEWS Total				
Monitoring Frequency				
Escalation of Care Y/N				
Initials by RN				
Initials by Sr. RN				

Note: Nurses are warned to Call Code 99 (100) when they get score of 3 in any single parameter or aggregate score of > 5

Score and monitoring frequency	4	Every Hourly
	3	Every 2 <sup>nd</sup> Hourly
	2	Every 4 <sup>th</sup> Hourly

[illegible]

[illegible]



**NAME ALERT**

Date	From: 9/1/24	To: 01/24	Bed No: 114	<b>INTAKE &amp; OUTPUT CHART</b>													
24 Hrs : Started Time : 7:00														Ended Time : 7:00			
NPO Started at :														NPO Over at :			
SHIFT	Morning		Afternoon											Night		Restricted Fluid (RF)	
INTAKE	800ml																
OUTPUT	600ml																
Total Intake:				Total Output:				Difference:									
<b>INTAKE (ml)</b>							<b>OUTPUT (ml)</b>										
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by		
			Type of Fluid	Additions	Amount												
8:00	150					150	8:30	200					350				
9:00	200					350	11:30	200					650				
11:00	150					500											

Dr. K. JAISHANKAR



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Mr.VENKATRAMAN SUBRAMANIAM

68/Male/MHI202400005

07/01/2024/IPH2024000053

Dr.K.JAISHANKAR



NAME ALERT

MHI/IP/2022/066



## Every heart beat counts

[illegible]



Every heart beat counts

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Patient Details (Affix Label here)

Name: Mr. Venkatasuman

UHID: 202400005

DOB: 07/11/24 Sex: Male

DOA: 08/11/24

Consultant: Dr. Rajhankar

Diagnosis:

T2DM / SH TN / SIP PTCA & CAD (2005) / SIP PTCA - Lx (2008) / AF - 37+

Height: 176 cms

Weight: 78.6 Kgs

Food allergies: Yes/No, if yes, specify

Religious Beliefs:

☐ Vegetarian

☒ Non Vegetarian

☐ Eggetarian

☐ Jain

Diet Prescription:

1600 calories, low fat, low salt, 1500ml fluid restricted,


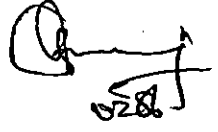
SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

Diabetic diet

(A) Patient's related Medical History				
1) Weight Change (overall change in past 6 months)				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
No weight change/gain	<5%	5-10%	10-15%	>15%
2) Dietary Intake				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Oral	No change	Sub-optimal solid diet	Full liquid diet/moderate overall decrease	Hypo-caloric liquid diet
Enteral/Parenteral Nutrition	Adequate/Excessive	Sub-optimal	Inadequate	Typo-caloric feeds
3) Gastrointestinal Symptoms Duration:				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
No symptoms	Nausea	Vomiting/moderate GI symptoms	Diarrhoea	severe anorexia
4) Functional Capacity (Nutrition related functional impairment) Duration:				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
None/improved	Difficulty with ambulation	Difficulty with normal activity	Light activity	Bed/chair-ridden with no or little activity
5) Co-morbidity (Disease and its relationship to nutrition requirements)				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Healthy	Mild co-morbidity	Moderate co-morbidity/age >75 years	severe co-morbidity	Very severe multiple co-morbidity
(B) Physical examination				
1) Decreased fat stores or loss of subcutaneous fat				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Normal	Mild	Moderate		Severe
2) Sign of muscle wasting				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Normal	Mild	Moderate		Severe
Total Score = Sum of above 7 components				
Nutritional Status: Based on this patient is				
Well Nourished		<input checked="" type="checkbox"/> (15-14) 9		
Moderately Malnourished		<input type="checkbox"/> (15 to 10)		
Severely Malnourished		<input type="checkbox"/> (19 to 35)		
Nutrition Intervention:				
<input checked="" type="checkbox"/> Oral		<input type="checkbox"/> Enteral <input type="checkbox"/> Parenteral		
Diet counselling provided: <input checked="" type="checkbox"/> Yes		<input type="checkbox"/> No		
Frequency of re-assessment: <input checked="" type="checkbox"/> Weekly		<input type="checkbox"/> Fort-night <input type="checkbox"/> Monthly		
Enteral/Parenteral <input type="checkbox"/> Daily		Calorie count: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

Dietitian Signature / Name / Date / Time:

8/11/24 16:00

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
<p>8/11/24 16:00</p>	<p>A 68 years old gentleman came c/o palpitation (on &amp; off) (1 day) was assessed. to be well-nourished as evident by SGA. K/C/O - T2DM / SHTN.</p> <p>patient shifted to cath lab for CAG + EP + RFA kept on NBM. patient returned to ward. NBM over. patient tolerated diabetic liquid diet can initiate on diabetic soft solid diet.</p> <p>oral intake is good.</p>	
<p>9/11/24 10:00</p>	<p>Educated the patient &amp; family on 1600 calories, low fat, low salt, diabetic, 1500ml fluid restricted diet on <u>discharge</u>.</p> <p>Emphasized on small frequent meals.</p> <p>Diet modifications &amp; clarifications done.</p> <p><u>Diet chart given on discharge</u></p>	

# DIET ORDERS (to be prescribed by Doctors only)

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
7/1/24	8:00pm	Ⓟ diet, salt diet	RD	183053					
8/1/24	4am	NPO from 4am	De	76572					
8/1/24	13:20	Em diet -	W	91812					
9/1/24	8:00	Diabetic diet	OS	165307					

# NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
	Evening					Evening			
8/1/24	Night	A-Monisha	0141	A		Night			
8	Morning					Morning			
8/1/24	Evening	Lacanya	0158	HL		Evening			
8/1/24	Night	Jenipriya	0284	SL		Night			
9/1/24	Morning	Lanika	0072	PL		Morning			
9/1/24	Evening	Hannah L. Wall	0105	Hay		Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			



Mr. VENKATRAMAN SUBRAMAN

68/Malc/MHI202400005

07/01/2024/IPH2024000053

Dr. K. JAISHANKAR



re)

## PSYCHOLOGICAL WELLBEING REPORT

Date: 09/01/24

Time: 3.25 pm.

Unit: 11A

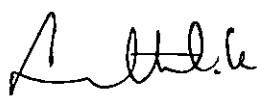
Clinical diagnosis: EPS + RFA, T2 DM

Surgery/ Procedure:

Impression: Sleep &amp; functioning well

- calm affect, oriented, responsive
- sleep without pill, appetite (N)
- no psychological distress reported.

Employee ID: MH10275PS4

  
 Signature of the Psychologist:

## PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: CAD, BPH, T2-Dm, SH 10, 51p chg Allergies if any: penicillin

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
1 <sup>st</sup> Floor (UH)	CATH LAB	8/1/24	8:35	EPS + RFA

Method of Transfer: ☐ On Bed ☒ On Wheelchair ☐ On Stretcher

### ASSESSMENT OF PATIENT:

General condition of Patient: ☒ Conscious ☐ Semi-conscious ☐ Un-conscious

Language Barrier: ☒ Yes ☐ No ☐ If Yes, specify: \_\_\_\_\_

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

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



Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO <sub>2</sub> (%)	BP (mmHg)	Pain Score
98.6	20b/m	90b/m	96%	120/80 mmHg	0/10

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

Any pre-medication given: Inj. Subcutaneous - 1g given

Any critical information: \_\_\_\_\_

Any specific recommendation: \_\_\_\_\_

	Signature	Name	Emp. No.	Date	Time
Handover by		M. D. Srinivas	0182	8/1/24	8:35
Handed over to		Dr. K. Jaishankar	0186	8/1/24	8:35



### After Procedure:


Procedure completed: ☒ Yes ☐ No | Any critical information: N/A

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

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO <sub>2</sub> (%)	BP (mmHg)	Pain Score
98.6	22 b/m	98 b/m	99%	130/80	0/10

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

	Signature	Name	Emp. No.	Date	Time
Handover by		Dr. K. Jaishankar	0186	8/1/24	13:12
Handed over to		Dr. K. Jaishankar	0188	8/1/24	13:10

CONSENT FOR ELECTROPHYSIOLOGY & ABLATION PROCEDURE	
<b>Mr. VENKATRAMAN SUBRAMAN</b>	
68 / Male / MHI202400005	
<b>Patient N</b> 07/01/2024 / IPH2024000053	<b>Sex: M/F</b>
Dr. K. JAISHANKAR	
<b>Consultant</b> 	<b>I No: UHID</b>

### CONDITION AND PROCEDURE

Dr. ~~JAISHANKAR~~ has explained that I have the following condition:

Each and every heartbeat is preceded by an electrical wave that travels from the right-upper corner of the heart called the sinus node (the natural pacemaker in the heart) to spread to the upper chambers (atria) and then through the junction of the top and bottom portions of the heart, called the AV Node and Bundle of HIS to the lower chambers (ventricle). This electrical wave then dies out and a fresh wave starts again from the sinus node for the next beat.

Diseases of the Sinus node can seriously delay the origin of heart beats resulting in a slow heart rate (Bradycardia) that can cause giddiness or loss of consciousness. In some disorders the rate of the heart is higher (Tachycardia) than the normal. This may be because an abnormal area in the heart either the atria (Supraventricular - SVT) or the ventricles (Ventricular - VT) starts behaving like the sinus node, but at a very fast rate. This can cause palpitations, chest discomfort, giddiness or breathlessness. In some other conditions an abnormal link of connection between the atria and the ventricle (Accessory Pathway) can cause the electrical wave to return back to the atria from the ventricle and then again back to the ventricle to cause a circus like movement of the electrical wave that causes the heart to gallop at rates over 200 per minute.

The abnormal sites of impulse creation or the abnormal links of communication can be accurately pin pointed by mapping with electrical wires that are kept in various key locations of the heart and mapping the progress of the electrical wave as it excites the heart.

After an injection of local anesthetic, a fine wire about 2mm in thickness (Catheter) is put into the vein in the groin / neck through a sheath that has a bleeding, preventing valve. The catheter is carefully passed into and maneuvered in to a particular region in the heart. In this fashion three to five catheters are inserted into various region of the heart and the other end of the catheter is connected by a junction box to a sophisticated computer called an Electrophysiology Laboratory.

The study of the electrical wave from the different regions of the heart that are displayed simultaneously on a multichannel monitor with electronic cursors help in accurately identifying the location of any abnormal focus that is discharging or abnormal connections that are conducting electrical waves and to diagnose the illness (Electrophysiology Study) and further on treat it by Radiofrequency Ablation.

### RISKS OF THIS PROCEDURE

The risk of coronary angiography depends on:

- (i) The nature of coronary artery disease
- (ii) The pumping status of the heart
- (iii) Your age and general health

These are some of the more serious risks that can happen, but are not the only risks:

Less than 1 in 10,000 (0.0001%)	(a) skin injury from radiation, causing, reddening of the skin
1 in 1000 people (0.001%)	(b) A stroke. This can cause paralysis and long term disability (c) Heart attack.

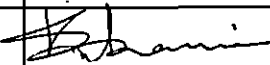
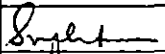

	(d) A dangerous reaction to the x-ray contrast medium (dye). If this happens, you may have severe reactions such as asthma, shock and convulsions. Death in extremely rare cases about 1 in 2,50,000 to 4,00,000 injections. (e) Need for major surgery to the leg at the puncture site. (f) Need for emergency heart surgery or angioplasty. (g) A higher lifetime risk from x-ray exposure. (h) Death (I) Perforation of the heart and blood vessels by the catheter that may require a surgery or reparative procedure
<b>1 in 100 people (0.01%)</b>	(j) the heart may not beat in a proper rhythm which will need urgent treatment (k) Surgical repair of the groin puncture site. This may need a longer stay in hospital. (l) Minor reaction to contrast medium such as hives. (m) Loss/impairment of kidney function due to the contrast medium
<b>1 in 20 people (0.05%)</b>	(n) Major bruising or swelling at the groin puncture site
<b>Most People</b>	(o) Minor bruising

#### PATIENT CONSENT:

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

On the basis of the above statements,

#### I AGREE TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship		V. SUBRAMANIAM	7/1/24	20:20
witness		VENKATESH (SON)	7/1/24	20:20
Doctor		DR. SATHYA		
Interpreter				

**மின்உடலியங்கியல் & உறுப்புநீக்கல் மருத்துவ செயல்முறைக்கான ஒப்புதல்**

நோயாளியின் பெயர்	வயது:	பாலினம்: ஆண்/பெண்
மருத்துவர்:	வார்டு & படுக்கை எண்:	UHID

நோய் நிலைமை மற்றும் மருத்துவ செயல்முறை

எனக்கு கீழ்க்கண்ட நோய் / பாதிப்பு நிலைகள் இருப்பதாக மருத்துவர்..... விளக்கியிருக்கிறார்:

ஒவ்வொரு இதயத்துடிப்பிற்கும் முன்னதாக ஒரு மின்சார அலை, சைனஸ் முனை (இதயத்தின் இயற்கையான பேஸ்மேக்கர்) என அழைக்கப்படும் இதயத்தின் வலது மேற்புற முனையிலிருந்து பயணித்து இதயத்தின் மேற்புற அறைகளுக்கு (அட்ரியா) பரவுகிறது; அதன்பிறகு AV முனை மற்றும் HIS-ன் தொகுப்பு என அழைக்கப்படும் இதயத்தின் மேல் மற்றும் கீழ்ப்பகுதிகளில் உள்ள சந்திப்புகள் வழியாக இதய கீழறைகளுக்கு (வெண்ட்ரிக்ளின்) அந்த மின்சார அலை பயணிக்கிறது. இந்த மின்சார அலை அதன்பிறகு முடிவுக்கு வருகிறது மற்றும் அடுத்த இதயத்துடிப்பிற்காக சைனஸ் முனையிலிருந்து ஒரு புதிய அலை மீண்டும் பயணிக்கத் தொடங்குகிறது.

சைனஸ் முனையில் ஏற்படும் நோய்கள், இதயத்துடிப்புகளின் தோற்றத்தை கடுமையாக தாமதிக்கச் செய்யும்; இதனால், உணர்விழப்பு நிலை அல்லது மயக்கத்தை விளைவிக்கின்ற மெதுவான இதயத்துடிப்பு (குறை இதயத்துடிப்பு) ஏற்படுகிறது. சில சீர்கேடுகளில் இதயத்துடிப்பு வேகம் இயல்பானதை விட அதிகமாக (மிகை இதயத்துடிப்பு) இருக்கும். இதய மேலறை (சுப்ராவெண்ட்ரிக்லர் - SVT) அல்லது இதய கீழறையில் (வெண்ட்ரிக்லர்-VT) ஒரு இயல்புக்கு மாறான பகுதி, சைனஸ் முனையைப்போல, ஆனால் மிக வேகமான விகிதத்தில் செயல்படுவதால் இது நிகழக்கூடும். இது, படபடப்புகளையும், மார்பு அசௌகரியத்தையும் மயக்கம் அல்லது சுவாசசிரமத்தையும் விளைவிக்கக்கூடும். வேறுசில பாதிப்பு நிலைகளில் இதய மேலறைக்கும், இதய கீழறைக்கும் இடையிலான ஒரு இயல்புக்கு மாறான இணைப்பு, இதய கீழறையிலிருந்து, மேலறைக்கு மின்சார அலையை திரும்பப்போகாமாறு விளைவிக்கும் மற்றும் அதன்பிறகு, கீழறைக்குத் திரும்ப வருமாறு செய்வதால், மின்சார அலை சுழற்சி போன்ற இயக்கத்தை அது உருவாக்கும். இதனால் ஒரு நிமிடத்திற்கு 200-க்கும் அதிகமான இதயத்துடிப்புகளோடு இதயம் வேகமாக விரைவதை இது விளைவிக்கும்.

இந்த உந்துவிசை உருவாக்கத்தின் இயல்புக்கு மாறான அமைவிடங்கள் அல்லது தகவல் பரிமாற்றத்தின் இயல்புக்கு மாறான இணைப்புகளை இதயத்தின் பல்வேறு முக்கிய அமைவிடங்களில் வைக்கப்படும் மின்சார வயர்களின் மூலம் வரைபடமாக்குவதன் வழியாக துல்லியமாக கண்டறிய முடியும். இதயத்தை மின்சார அலை கிளர்ச்சியூட்டுகிறபோது அதன் முன்னேற்றத்தை இதன்மூலம் மேப்பிங் செய்ய முடியும்.

குறிப்பிட்ட அமைவிடத்தில் தரப்படும் மயக்க மருந்து உட்செலுத்திய பிறகு சுமார் 2 மி.மீ. அடர்த்தி கொண்ட ஒரு மெல்லிய கம்பி (கத்தீட்ரர்), இரத்தக்கசிவை தடுக்கின்ற ஒரு வால்வைக் கொண்டிருக்கும் ஒரு உறை வழியாக, இடுப்புக்கவட்டை / கழுத்திலுள்ள சிரை நரம்பு வழியாக உட்செலுத்தப்படுகிறது. இதயத்தில் ஒரு குறிப்பிட்ட பகுதிக்குள் செல்லுமாறு இந்த கத்தீட்ரர் மிக கவனத்தோடு அனுப்பப்படுகிறது. இந்த வழிமுறையின் மூலம் இதயத்தின் பல்வேறு பகுதிகளுக்குள் 3 முதல் ஐந்து கத்தீட்ரர்கள் வரை உட்செலுத்தப்படுகின்றன. கத்தீட்ரின் மற்றொரு முனையானது, ஒரு மின்உடலியங்கியல் பரிசோதனையாக என் அழைக்கப்படும் ஒரு நவீன கணினியுடன் ஒரு ஜங்ஷன் பாக்ஸ் மூலம் இணைக்கப்பட்டிருக்கும்.

இதயத்தின் பல்வேறு பகுதிகளிலிருந்து, மின்சார அலையின் மீது செய்யப்படும் ஆய்வு எலக்ட்ரானிக் கர்சர்கள் உடன் கூடிய ஒரு மல்டிசேனல் மானிட்டரில் அதேநேரத்தில் காட்சிப்படுத்தப்படுகின்றன. மின்சார அலைகளை வெளியேற்றுகின்ற அல்லது இயல்புக்கு மாறான கூர்நோக்க அமைவிடத்தை அல்லது இவைகளை கடத்துகின்ற இயல்புக்கு மாறான பிணைப்புகளை துல்லியமாக அடையாளம் காண இது உதவுகிறது. அத்துடன் நோயை துல்லியமாக அடையாளம் கண்டு உறுதிசெய்யவும் மற்றும் (மின்உடலியங்கியல் ஆய்வு) அதன்பிறகு கதிரியக்க அதிர்வெண் நீக்கத்தின் வழியாக அதற்கு சிகிச்சையளிக்கவும் இது உதவுகிறது.

இம்மருத்துவ செயல்முறையின் இடர்கள்

கரோனரி ஆஞ்சியோகிராஃபியில் ஏற்படும் இடர்கள் கீழ்க்கண்டவற்றை சார்ந்திருக்கிறது:

- கரோனரி தமனி நோயின் தன்மை
- இதயத்தின் இரத்தத்தை உடலின் பிற உறுப்புகளுக்கு பம்பு செய்யும் திறன்நிலை.
- உங்களது வயது மற்றும் பொதுவான உடல்நலம்

நிகழக்கூடிய மிகத் தீவிரமான இடர்களுள் இவைகள் சில; ஆனால், இவைகள் மட்டும் முழுமையான பட்டியல் அல்ல:

10,000 நபர்களில் 1 நபருக்கும் குறைவாக (0.0001%)	(a) கதிர்வீச்சு சிகிச்சையினால் ஏற்படக்கூடிய சரும காயம்; இதன் விளைவாக சருமத்தின் மேற்பரப்பு சிவந்துவிடும்
1000 நபர்களில் 1 நபருக்கும் குறைவாக (0.001%)	(b) பக்கவாதத்தையும் மற்றும் நீண்டகால திறனிழப்பையும் (c) மாரடைப்பையும் விளைவிக்கக்கூடும்.



	<p>(d) எக்ஸ்-ரே கான்ட்ராஸ்ட் மீடியத்தின் (டை / சாயம்) ஒரு ஆபத்தான எதிர்வினை. இது நிகழுமானால், ஆஸ்துமா, அதிர்ச்சி மற்றும் வலிப்புத்தாக்கங்கள் போன்ற கடுமையான எதிர்வினைகள் உங்களுக்கு வரக்கூடும். 2,50,000 முதல் 4,00,000 வரையிலான ஊசி மருந்து செலுத்தலில் ஒரு நபருக்கு உயிரிழப்பு - மிக மிக அரிதான நேர்வுகளில்.</p> <p>(e) காலில் துளையிட்ட இடத்தில் பெரிய அறுவைசிகிச்சைக்கான அவசியம்.</p> <p>(f) அவசர நிலை நிகழ்வாக இதய அறுவைசிகிச்சை அல்லது ஆஞ்சியோபிளாஸ்டிக்கான அவசியம்.</p> <p>(g) எக்ஸ்-ரே / ஊடுகதிருக்கு வெளிப்படுவதால் உயர்ந்திருக்கும் ஆயுட்கால இடர்வாய்ப்பு</p> <p>(h) உயிரிழப்பு</p> <p>(i) அறுவைசிகிச்சை அல்லது பழுதுநீக்கும் மருத்துவ செயல்முறை அவசியப்படுகிறவாறு கட்டீட்ரால் இதயம் மற்றும் இரத்தநாளங்களில் துளை விழுதல்.</p>
1 in 100 people (0.01%)	<p>(j) முறையான லயத்துடன் இதயத்தாடிப்பு இருக்காது; இதற்கு அவசரசிகிச்சை தேவைப்படும்.</p> <p>(k) இடுப்பு கவட்டையில் துளையிட்ட அமைவிடத்தில் அறுவைசிகிச்சை சார்ந்த பழுதுநீக்கல்; மருத்துவமனையில் நண்டகாலம் தங்கி சிகிச்சைப்பெறுவது இதற்கு அவசியமாக இருக்கலாம்.</p> <p>(l) கான்ட்ராஸ்ட் மீடியத்திற்கு தோலரிப்பு போன்ற சிறிய எதிர்வினை.</p> <p>(m) கான்ட்ராஸ்ட் மீடியத்தின் காரணமாக சிறுநீரக செயல்திறன் இழப்பு / பாதிப்பு</p>
1 in 20 people (0.05%)	<p>(n) இடுப்புக் கவட்டையில் துளையிட்ட அமைவிடத்தில் பெரிய அளவிலான சிராய்ப்பு காயம் அல்லது வீக்கம்</p>
Most People	<p>(o) சிறிய அளவிலான சிராய்ப்பு காயம்</p>

#### நோயாளியின் ஒப்புதல்:

சிகிச்சையளிக்கும் மருத்துவர் எனது மருத்துவ நிலை குறித்தும் மற்றும் செய்ய திட்டமிடப்பட்டிருக்கும் மருத்துவ செயல்முறை குறித்தும் டாக்டர் விளக்கியிருக்கிறார் என நான் உறுதி செய்கிறேன். எனக்கு குறிப்பாக பொருந்துகின்ற இடர்கள் உட்பட, இந்த மருத்துவ செயல்முறை, உணர்விழப்பிற்கான மருந்து ஆகியவற்றில் உள்ள இடர்கள் / சிக்கல்கள் எழுமானால், அதனால் நிகழ சாத்தியமுள்ள விளைவுகள் உட்பட இச்செயல்முறையின் இடர்களை நான் புரிந்து கொண்டுள்ளேன். தொடர்புடைய பிற சிகிச்சை விருப்பத்தேர்வுகள், அவைகளின் இடர்கள் மற்றும் இச்சிகிச்சையை ஏற்க மறுப்பதற்கு எனக்கு இருக்கும் உரிமை ஆகியவை பற்றியும் மருத்துவர் விளக்கிக் கூறியிருக்கிறார். எனது மருத்துவ / நோய் நிலை குறித்தும் மற்றும் இச்சிகிச்சை செயல்முறையை மேற்கொள்ளாததால் ஏற்பட வாய்ப்புள்ள இடர்கள் பற்றியும் அவர் விளக்கியிருக்கிறார். எனது தற்போதைய உடல்நிலை பாதிப்பு, செய்யப்படவுள்ள மருத்துவ செயல்முறை, அதன் இடர்வாய்ப்புகள் மற்றும் எனது சிகிச்சை விருப்பத்தேர்வுகள் பற்றி கேள்விகள் கேட்கவும், கவலைகளை வெளிப்படுத்தவும் எனக்கு வாய்ப்பளிக்கப்பட்டது என்றும் மற்றும் நான் முழு திருப்தியடையும் வகையில் என்னுடைய அனைத்து கேள்விகளும், கவலைகளும் விவாதிக்கப்பட்டன மற்றும் பதிலளிக்கப்பட்டன நிகழ்வதற்கு அரிதான சிக்கல்கள் ஏற்படும் நேர்வில் இரத்தமேற்றல், ஒரு கூடுதல் மருத்துவ செயல்முறை அல்லது அறுவைசிகிச்சை எனக்குத் தேவைப்படலாம் என்று நான் புரிந்து கொள்கிறேன். சிகிச்சை செயல்முறையின்போது உயிருக்கு ஆபத்தான நிகழ்வுகள் நிகழுமானால், அவைகளுக்கு உரியவாறு சிகிச்சையளிக்கப்படும் என்று மருத்துவர் என்னிடம் விளக்கிக் கூறியிருக்கிறார். இந்த சிகிச்சை செயல்முறையானது எனது நோய் நிலையை குணமாக்கி மேம்படுத்தும் என்பதற்கு உத்தரவாதம் ஏதும் செய்யப்படவில்லை என்றும் நான் புரிந்துகொள்கிறேன்.

மேற்கூறப்பட்ட அறிக்கைகளின் அடிப்படையில்,

இந்த மருத்துவ செயல்முறை எனக்கு செய்யப்படுவதற்கு நான் சம்மதிக்கிறேன்.

	கையொப்பம்	பெயர்	தேதி	நேரம்
நோயாளி/பாதுகாவலருடனான உறவுமுறை				
சாட்சி				
மருத்துவர்				
மொழியெயர்ப்பாளர்				



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# CORONARY ANGIOGRAM REPORT

<b>PATIENT NAME</b>	<b>: Mr. VENKATRAMAN SUBRMANIAM</b>	<b>UHID</b>	<b>: MHI202400005</b>
<b>AGE/GENDER</b>	<b>: 68Years / MALE</b>	<b>IP NO</b>	<b>: IPH2024000053</b>
<b>CONSULTANT</b>	<b>: Dr. Jaishankar. K MD., DM., FIAMS</b>	<b>D.O.A</b>	<b>: 08 .01.2024</b>
	Director and Clinical Lead	<b>D.O.P</b>	<b>: 08.01.2024</b>
	Cardiology and Electrophysiology		

CATH DATE	08.01.2024	DONE BY	DR. JAISHANKAR
CATH NO	3554	ASSISTED BY	SN. SATHYA
CATH DURATION	5 MINS	TECHNICIAN	MR. TAMIL
HEIGHT WEIGHT	176CMS 78KGS	PHYSICIAN ASSISTANT	MS. SHALINI

**CLINICAL DIAGNOSIS:** ATRIAL FLUTTER WITH VARYING BLOCK, MODERATE LV DYSFUNCTION, EF – 37%, S/P PTCA TO LAD – (2005), S/P PTCA TO LCX & RCA – (2008), S/P CABG (SVG TO LAD & PDA) – APOLLO HOSPITAL, 30.04.2022, S/P STERNAL WIRE REMOVAL + WOUND DEBRIDEMENT (09.07.2022 - APOLLO HOSPITAL, SYSTEMIC HYPERTENSION, TYPE II DIABETES MELLITUS, BPH.

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

**APPROACH** : RIGHT FEMORAL ARTERY  
**SHEATH** : 6FR  
**CATHETER** : 6FR JL / JR  
**CONTRAST MATERIAL** : NON- IONIC, CONTRAPAQUE  
**MEDICATIONS** : Inj. Heparin 2500 IU

**COMMENTS:**

LMCA - NORMAL. BIFURCATES INTO LAD AND LCX.

LAD - TYPE III VESSEL AND GIVES RISE TO 1 DIAGONAL ; NORMAL. PROXIMAL LAD HAS LUMINAL IREGULARITIES.MID LAD STENT INSITU AND PATENT. DISTAL LAD HAS TOTAL OCCLUSION.

LCX - NON-DOMINANT AND GIVES RISE TO 3 OMs. PROXIMAL LCX HAS LUMINAL IRREGULARITIES.DISTAL LCX STENT INSITU WITH TOTAL OCCLUSION (ISR).OMs HAVE LUMINAL IRREGULARITIES.

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RCA - DOMINANT AND GIVES RISE TO PDA AND PLV BRANCHES. PROXIMAL RCA HAS LUMINAL IRREGULARITIES. MID RCA HAS 80% TUBULAR STENOSIS. DISTAL RCA HAS STENT INSITU WITH TOTAL OCCLUSION (ISR)

**GRAFT ANGIOGRAM:**

SVG → LAD - PATENT GRAFT. DISTAL LAD AFTER ANASTOMOSIS HAS DIFFUSE DISEASE.

SVG → PDA - PATENT GRAFT

**IMPRESSION:**

NATIVE TRIPLE VESSEL DISEASE

PATENT SVG GRAFTS TO LAD / PDA, PATENT LAD STENT/ ISR OF LSX & RCA STENTS.

MODERATE LV DYSFUNCTION

RIGHT DOMINANT SYSTEM

**ADVICE:**

OPTIMAL MEDICAL MANAGEMENT

**CONSULTANT SIGNATURE**

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

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**Dr. K. JAISHANKAR**  
Reg. No: 49448

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**ELECTROPHYSIOLOGY STUDY + RADIOFREQUENCY ABLATION REPORT****PATIENT NAME : MR. VENKATRAMAN SUBRAMANI****PATIENT ID : MHI202400005****AGE/ SEX : 68 YEARS/ MALE****IP NO : IPH2024000053****CONSULTANT : Dr. Jaishankar. K MD., DM., FIAMS****D.O.A : 07.01.2024**

Director and Clinical Lead

**D.O.P : 08.01.2024**

Cardiology and Electrophysiology

CATH DATE	08.01.2024	DONE BY	DR. K.JAISHANKAR
CATH NO	3554/3555	ASSISTED BY	MS. SATHYA
CATH DURATION	1.5 HOURS	TECHNICIAN	Mr. JAYAGAR
FLUORO TIME	30 MINS	PHYSICIAN ASSISTANT	MS. SHALINI
HEIGHT	176 CMS	WEIGHT	78.6 KGS

**ACCESS:**

1. RIGHT FEMORAL VEIN X 1 (8Fr FOR HD GRID CATHETER & ABLATION)
2. LEFT FEMORAL VEIN X 2 (6Fr FOR CS, HIS BUNDLE)
3. RIGHT FEMORAL ARTERY X 1 (5Fr FOR ARTERIAL PRESSURE MONITORING)

SITE	CATHETERS
HIS	6F QUADRIPOlar
RA	8F HD GRID
CS	6F DECAPOLAR
MAPPING & ABLATION	8F THERAPY

**INDICATION :**

1. ATRIAL FLUTTER WITH VARYING BLOCK
2. H/O PALPITATIONS 4 MONTHS

**ECG:** ATRIAL FLUTTER WITH VARYING CONDUCTION BLOCK (1:1, 2:1, 3:1) RATE @ 114BPM.**ECHO:** DILATED ATRIA. GLOBAL HYPOKINESIA, MODERATE LV SYSTOLIC DYSFUNCTION. EF – 38%.**CORONARY ANGIOGRAM:** NATIVE TRIPLE VESSEL DISEASE

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## **ELECTROPHYSIOLOGY STUDY:**

RR	752 ms
QRS	106 ms
QTc	459 ms
QT	398 ms

THERE WAS NO VA CONDUCTION AT BASELINE RULING OUT THE ACCESSORY PATHWAY.

### **1. TACHYCARDIA ANALYSIS:**

PATIENT WAS IN INCESSANT ATRIAL FLUTTER AT START OF STUDY.

USING "NAVX" ENSITE 3D MAPPING - ACTIVATION, PROPAGATION & ENTRAINMENT MAPS WERE DONE. RA GEOMETRY WAS CREATED.

THE TACHYCARDIA WITH A VARIABLE CL: 250 – 270 MSEC WAS SEEN. USING CAVO TRICUSPID ISTHMUS FOR CONDUCTION.

### **2. ENTRAINMENT MAPPING:**

ENTRAINMENT FROM HD GRID IN MID RA COULD BE DONE WITH A PPI – TCL = 0 MSEC AND ENTRAINMENT FROM MID CORONARY SINUS PPI – TCL ~ 40 MSEC. HOWEVER FROM CTI IT WAS 0 MSEC. THUS IT WAS SUGGESTIVE OF A COUNTER CLOCKWISE TYPICAL ATRIAL FLUTTER USING THE CAVOTRICUSPID ISTHMUS AS ZONE OF SLOW CONDUCTION.

### **3. RADIO FREQUENCY ABLATION:**

USING 7F FLEXIBILITY ST. JUDE COOL PATH (35W, 43 °C, 60 – 120 SEC) , CTI (6'0 TRICUSPID ANNULUS) SITE WAS TARGETED FOR ABLATION ATRIAL FLUTTER TERMINATED DURING ABLATION.

THEREAFTER FURTHER ABLATION WAS DONE WITH ATRIAL PACING ALONG THE CAVOTRICUSPID ISTHMUS. AFTER COMPLETION OF CTI LINE .

BIDIRECTIONAL BLOCK COULD BE DEMONSTRATED. PACING FROM LRA- TRANS ISTHMUS TIME 150 SEC. PACING FROM CORONARY SINUS OS TO TRANS ISTHMUS TIME TO LRA WAS 150 SEC.

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**PATIENT  
HELPLINE**  
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### POST RFA:

- DIFFERENTIAL PACING WAS SUGGESTIVE OF NO CONDUCTION ACROSS THE LINE.

AVW	360 ms
AERP	S1 500 / S2 400 / S3 200 ms

### POST RFA INTERVALS:

POST RFA BASELINE INTERVALS ARE NORMAL.

- POST PROCEDURE WAS UNEVENTFUL. PATIENT WAS HEMODYNAMICALLY STABLE AND SHIFTED TO CCU FOR OBSERVATION. RIGHT AND LEFT FEMORAL VENOUS AND ARTERIAL SHEATH REMOVED AND APPLIED PRESSURE BANDAGE.

### IMPRESSION:

- COUNTER CLOCKWISE TYPICAL ATRIAL FLUTTER - CTI DEPENDANT FROM RIGHT ATRIUM.
- SUCCESSFUL RFA OF ATRIAL FLUTTER.

### PLAN:

TO CONTINUE ANTI ARRHYTHMIC & ANTICOAGULANT DRUGS.

**CONSULTANT SIGNATURE**

**Dr. Jaishankar. K MD., DM., FIAMS**  
Director and Clinical Lead  
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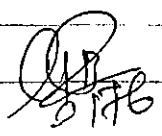
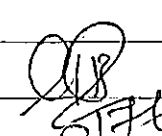
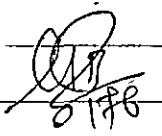
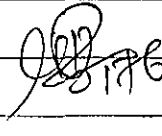
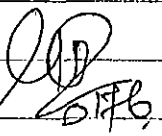
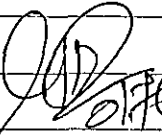
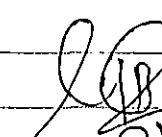
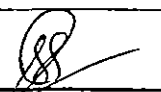
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## NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
8/1/24	Cath Lab.	
8-35	=> Pt Received from 1st floor to cath Lab. conscious and oriented.	 0176
9-00	=> vitals stable HR: 92 b/min, BP: 140/78 mmHg SpO2: 98%	
9-00	=> IV line Pt and left side Patent. VIP Score: 0/5	 0176
10-45	=> IVE: NS 30ml/hr IV started. sterile drapping done. CAG + EPs + RFA 3D started	 0176
10-30	=> Rt femoral arterial and venous approach under local anaesthesia.	 0176
10-40	=> IN: Heparin 1000 IU IV given O/B Dr. J. S. (Sir)	
10-45	=> BP: 154/68 (98) mmHg, HR: 92 b/min SpO2: 100% vitals stable.	 0176
11-20	=> IN: Heparin 1000 IU IV given O/B Dr. J. S. (Sir)	
11-30	=> IN: Fentanyl 25 mcg + IN: Emerol Amg IV given O/B Dr. J. S. (Sir)	
12-15	=> BP: 135/60 (65) mmHg, HR: 76 b/min SpO2: 99% vitals stable.	 0176
12-30	=> Procedure CAG + EPs + RFA 3D done. Rt femoral arterial and venous sheath removed. Tight Padded bandage applied. no oozing & hemostasis	 0176
13-10	=> Pt shifted to ICU all reports hand over to R/N Lavanya	
Document endorsed by	Signature 	Name Sathya
	Emp. No. 0016	Date 8/1/24
		Time 13-10

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

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Mr. VENKATRAMAN SUBRAMAN

68 / Male / MHI202400005

07/01/2024 / IPH2024000053

Dr. K. JAISHANKAR

Name of the Procedure : CABG + EPC + RFA 3D Location : Cath Lab. Date & Time : 8/1/24

Does the Procedure involve Procedural Sedation : ☐ Yes ☒ No

SIGN IN <u>10:15</u> Before Induction of Procedural Sedation		TIME OUT <u>10:30</u> After procedural Sedation and before procedure		SIGN OUT <u>10:30</u> When Doctor indicates that the Procedure is completed	
(Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)		(Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure)			
Patient Confirmation		All team members introduce themselves by Name and Role		To be done for each procedure in case of multiple procedures	
Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Name of the Procedure done written down <input checked="" type="checkbox"/> Yes <u>CABG + EPC + RFA 3D</u>	
Procedure	<input checked="" type="checkbox"/> Yes	Procedures <u>CABG + EPC + RFA 3D</u>	<input checked="" type="checkbox"/> Yes	Name and site of all specimens / investigations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA confirms labeling and sent to lab	
Side	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	Side <u>Rt femoral arterial and venous approach</u>	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA		
		Expected Blood loss <u>NA</u>			
Consent	<input checked="" type="checkbox"/> Yes	Position <u>Supine</u>	<input type="checkbox"/> Yes	Any recovery concerns : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Known Allergy	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please specify <u>penicillin</u>	Consent	<input type="checkbox"/> Yes	If Yes, Pls. specify :	
		Required equipment and implants available	<input type="checkbox"/> Yes <input type="checkbox"/> NA		
Difficult airway / aspiration risk / dentures	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, equipment and assistance available	Essential Imaging displayed	<input type="checkbox"/> Yes <input type="checkbox"/> NA		
		Antibiotic prophylaxis within last 60 minutes	<input type="checkbox"/> Yes <input type="checkbox"/> NA		
Possibility of hypothermia	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, warmer in place	Name of the Antibiotic given		Any Equipment / instrument problem that needs to be addressed : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
		Venous Thromboembolism Prophylaxis Provided	<input type="checkbox"/> Yes <input type="checkbox"/> NA	If Yes, Pls. specify :	
All concerned anesthesia equipment and medication check complete		Anticipated duration briefed	<input type="checkbox"/> Yes		
<input type="checkbox"/> SpO2 <input type="checkbox"/> NIBP <input checked="" type="checkbox"/> Others pls. specify <u>ECG</u>		Anticipated blood loss briefed	<input type="checkbox"/> Yes <input type="checkbox"/> NA		
Pre OP medication taken	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Adequate fluids and blood available	<input type="checkbox"/> Yes <input type="checkbox"/> NA		
		Team briefed on any critical or unexpected steps	<input type="checkbox"/> Yes		
Required equipment for procedure available	<input type="checkbox"/> Yes <input type="checkbox"/> NA	For procedural sedation cases		Corrective action :	
		Any patient specific concerns :	<input type="checkbox"/> Yes <input type="checkbox"/> None		
		Intra procedure glycaemic control	<input type="checkbox"/> Yes <input type="checkbox"/> NA		
		Any concerns about sterility	<input type="checkbox"/> Yes <input type="checkbox"/> None		

Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure :	Nurse : <u>R.N. Sandhya</u>	Technician : <u>mo. Sathish</u>	Others Please Specify :
Date : <u>8/1/24</u>	Date : <u>8/1/24</u>	Date : <u>8/1/24</u>	Date : <u>8/1/24</u>	Date : <u>8/1/24</u>
Time : <u>12:45</u>	Time : <u>12:45</u>	Time : <u>12:45</u>	Time : <u>12:45</u>	Time : <u>12:45</u>





Patient Name	Mr. VENKATRAMAN SUBRAMAN
UHID / IP :	68 / Male / MH1202400005 07/01/2024 / IPH2024000053
Consultant :	Dr. K. JAISHANKAR

Age / Sex: 68 y / M.

Ward Unit: 1<sup>st</sup> Floor

Diagnosis: CAD, BPH, T2DM, COPD, HTN, S/P CABG

PARAMETERS	YES	NO	NA
Vital signs : BP: 120/80 Temp: 98.6 Pulse: 90 RR: 20 SPO2: 98			
Urine voided	✓		
Bowel preparation		✓	
Pre-procedure medication administered			
Procedure site marked		✓	
Skin preparation done	✓		
NPO 4:00			
Loose Tooth removed			✓
Contact lenses / Eye glasses removed			✓
Prosthesis present			✓
Jewellery/Nail polish removed			
Checked for Allergies (Drug / food) not known.			
IV line/In-situ	✓		
Consent taken	✓		
Investigation reports / Documents received	✓		
Signature of Nurse : [Signature]	Date & Time : 8/11/24 at 8:20.		

Time	HR / min	RR / min	BP mmHg	SpO2%	Medication / Remarks	Sign. of Nurse
10.15	92 bt / mt	22 bt / mt	140 / 70 mmHg	99%	-	QIP 20176
10.30	96 bt / mt	22 bt / mt	130 / 71 (91)	99%	-	QIP 20176
11.00	104 bt / mt	22 bt / mt	120 / 68 / 90	100%	-	QIP 20176
11.30	96 bt / mt	22 bt / mt	152 / 72 (92)	100%	-	QIP 20176
12.00	74 bt / mt	22 bt / mt	130 / 58 (82)	99%	-	QIP 20176
12.20	74 bt / mt	22 bt / mt	135 / 60 (85)	100%	-	QIP 20176
Procedure got over						

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

Time : 12.45 Route : Rt femoral arterial and venous approach  
 Complication : Nil

BP : 135/60 (85) mmHg, HR : 96 bt/mt, RR : 22 bt/mt, SpO2 : 100%

Distal Pulse : felt, Puncture Site : no oozing & hemostasis

**Advise:**

- ◆ Shift To: Ward / ICU
- ◆ Bed rest up to 6 hours
- ◆ Observe puncture site for bleeding
- ◆ Watch for Pulse in Rt femoral artery.
- ◆ Diet Normal DM diet.
- ◆ Inform Duty Medical Officer SOS
  - a) If patient complains of any Discomfort
  - b) If dressing is Loose or Socked with Blood
  - c) If limbs are Cold / Absent Pulse
- ◆ Remove Rt femoral arterial and venous dressing on 9/1/24 at 11.00 AM / PM after informing to the consultant.
- ◆ Special instruction if any: Nil

Name & Signature of Consultant

**POST PROCEDURE OBSERVATION**

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse
8/1/24 12.45	110/70	76	22	99-1	no oozing & hemostasis	Good	-	<u>[Signature]</u>
13.00	123/74	76	22	99-1	no oo 2hrs & hemostasis	Good	-	<u>[Signature]</u>
13.10	128/80	74	22	99-1	no oozing & hemostasis	Good	-	<u>[Signature]</u>

**Nurses Notes :**

procedure CAGI + EPS + RFA 3D done. Rt femoral arterial and venous sheath removed. Tight plaster bandage applied. no oozing & hemostasis.

Condition at the end of procedure : ☒ Stable ☐ Critical

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

Name & Signature of the Nurse :

Date & Time :

[Signature]

8/1/24 @ 13.00



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(A Unit of United Alliance Healthcare Pvt Ltd)



**NAME ALERT**

Mr. VENKATRAMAN SUBRAMAN

68/Male/MHI202400005

07/01/2024/IPH2024000053

Dr. K. JAISHANKAR



Consultant:

2/2022/053

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**ALLERGY**

*penicillin*

## NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 7/1/24 Time of Arrival: 19:30 Mode of Admission: ☐ Walking ☐ Wheelchair ☐ Stretcher

Accompanied by Relative: ☒ Yes ☐ No If Yes, Name of the Relative: Mrs. Vengal Raman

Relationship with Patient: — Contact Person's Name: — Relationship: Spouse

Contact No.: 98205 20328 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-Morbidity 34 yrs Yes If yes specify

Drugs History: Antiplatelet — (Specify)

Psychological Status: ☒ Calm ☐ Anxious ☐ Withdrawn ☐ Agitated ☐ Depressed ☐ Sleeping Difficulty

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

If Yes, specify details: —

Socio Economic Status: ☐ Employed ☐ Retired ☐ Own Business ☐ Home-Maker ☐ Others: —

Vital Signs: Temp: 98.6°F | Pulse / HR: 92 (beats/min) | BP: 102/75 (mmHg)

Respiration: 20 (breaths/min) | SpO<sub>2</sub>: 96 (%) | CBG: 164 (mg/dl) | Height: 176 (cms) | Weight: 78 (kgs)

Allergies / Adverse Reaction: ☐ Yes ☐ No ☒ Medication ☐ Blood Transfusion ☐ Food ☐ Not known

If Yes, specify: penicillin

Pain: ☐ Yes ☒ No. If Yes, Score: — Pain Scale Used: ☐ Wong-Baker FACES Pain Rating Scale (7-12 years)

☐ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)

Duration: — Location: —

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

### Nutritional Screening:

Last 3 months Appetite: ☐ Increased ☐ Decreased ☒ No Change

Last 3 months Weight: ☐ Increased ☐ Decreased ☒ No Change

Type of Patient: ☒ Diabetic ☐ Non Diabetic Type of Diet: diabetic diet

Dietician Informed: ☐ Yes ☐ No. If Yes, mention the Name: Mrs. Catherine Time: 19:00

Orient Patient if: ☒ Conscious

Orient Patient Attendant if: ☐ Unconscious ☐ Disoriented

☒ Room ☐ Side Rails ☐ Toilet Bell ☒ Patient Information Board ☒ Bathroom ☐ Bed Controls

☒ Use of Footstool ☐ Grab Bars ☒ Nurses Call Bell ☐ Television ☒ Light Controls ☐ Telephone

### Functional Assessment:

Particular	Assessment	Remarks	Outcome
Visual Impairment	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Hearing Impairment	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Chewing Difficulty	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Walking Difficulty	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

*Angio plasty - 2005, 2002.  
CABG. 2022.*

77-11-11

Daily Activity Of Living:			
Activity	Independent	Assisted	Dependent
Bathing	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet Use	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pressure Injury Risk Assessment: Braden Scale					
Sensory Perception	Score	Moisture	Score	Degree of Activity	Score
No Impairment	4	Rarely Moist	4	Walks Frequently	4
Slightly Limited	3	Occasionally Moist	3	Walks Occasionally	3
Very Limited	2	Very Moist	2	Chair Fast	2
Completely Limited	1	Constantly Moist	1	Bed Fast	1
Mobility	Score	Nutrition	Score	Friction & Shear	Score
No Limitation	4	Excellent	4	No apparent problem	3
Slightly Limited	3	Adequate	3	Potential Problem	2
Very Limited	2	Probably In-Adequate	2	Problem Present	1
Completely immobile	1	Very Poor	1		

**Score Interpretation:** Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13;

High Risk: 12 - 10; Severe Risk: 9 - 6

**Total Score:** 19 **Action needed:** ☐ Yes ☐ No **Pressure injury present at the time of admission:** ☐ Yes ☐ No

If yes, Location: \_\_\_\_\_ Grade: \_\_\_\_\_ Size: \_\_\_\_\_

Witnessed by: \_\_\_\_\_ Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

### MODIFIED MORSE FALL ASSESSMENT SCALE (Age above 16 years)

#### Fall Risk Assessment (Modified Morse Scale):

Variables		Numeric Value
History of falling (immediate or within 6 months)	No	0
	Yes	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0
	Yes	15
<b>Ambulatory Aid</b>		
None / Bed Rest / Nurse Assist		0
Crutches / Cane / Walker		15
Furniture		30
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0
	Yes	20
<b>Gait</b>		
Normal / Bed Rest / Wheel Chair		0
Weak		10
Impaired		20
<b>Mental Status</b>		
Oriented to own stability		0
Overestimated or forgets limitations		15
<b>Medications</b>		
Includes PCA / opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, hypoglycemics, sedatives, immunosuppressant and psychotropics	No	0
	Yes	15
<b>Score Interpretation:</b> 0-24: Low-risk; 25-44: Medium Risk; Above 45: High Risk	<b>Total Score</b>	30

**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	No	Remarks (please specify)
Terminally ill patients		<input checked="" type="checkbox"/>	
Patients with intense chronic pain		<input checked="" type="checkbox"/>	
Woman in labor or experiencing termination of pregnancy		<input checked="" type="checkbox"/>	
Patients with emotional or psychological distress		<input checked="" type="checkbox"/>	
Patient suspected of drug or alcohol dependency		<input checked="" type="checkbox"/>	
Victims of abuse and neglect		<input checked="" type="checkbox"/>	
Patients whose immune system is compromised		<input checked="" type="checkbox"/>	
Patient with infections and communicable diseases		<input checked="" type="checkbox"/>	
Does the patient have implants		<input checked="" type="checkbox"/>	
Has tracheotomy been done		<input checked="" type="checkbox"/>	
Has colostomy been done		<input checked="" type="checkbox"/>	
Any other potential needs of the patient		<input checked="" type="checkbox"/>	

Prostate hypertrophy -

## 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
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
2	Bedridden recently >3 days or major surgery within four weeks	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
5	Entire leg swollen (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
6	Localized tenderness along the deep venous system (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
9	Previously documented DVT (Assess for both legs)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

### Risk Score Interpretation (Probability of DVT):

Final Score

Tick the score obtained (✓)

Action Taken

Date

Time

Low Risk

-2 to 0

low

Moderate Risk

1 to 2

High Risk

3 to 8

### Personal Belongings / Valuables:

Valuables	Description	With Patient	With Patient's Attendant	Name & Signature of the Patient / Patient's Attendant	Remarks
Dentures	<input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Both <input checked="" type="checkbox"/> Nil				
Hearing Aid	<input type="checkbox"/> Right <input type="checkbox"/> Left <input checked="" type="checkbox"/> Nil				
Eye glasses / Contact lens	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
Jewellery	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Other valuables (specify)					

Report (List of X-ray, ECG, lab reports retained with the nurse):

Patient / Patient's Attendant	Sign.	Name	Emp. No.	Date	Time
	<i>[Signature]</i>	VENKATARAMAN . S.	Relationship Son	7/1/24	19.30
Nurse	<i>[Signature]</i>	Agasthina	0116	7/1/24	19.30
Unit In-Charge	<i>[Signature]</i>	S. Nalini	0024	7/1/24	10.0

## PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 7/1/24 Shift: ☐ Morning ☐ Evening ☒ Night

**S**

### SITUATION

Diagnosis: BPH, CAD

NEWS / PEWS Score: -

Ventilator day: -

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: -

GCS: 15/15

POD: -

Central line days: -

VIP Score: -

**B**

### BACKGROUND

Type of surgery: -

Date of surgery: -

Allergies if any: Not Allergic

On room air / oxygen: on Room air

IV fluids on flow: -

Complaints / New Symptoms in last shift: -

**A**

### ASSESSMENT

Vital Signs: Temp: 98.6°F | Pulse / HR: 102 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/80 (mmHg) | SpO<sub>2</sub>: 96 (%) | Height: 176 (cms) | Weight: 78.4 (kgs) | BMI: 23.5 kg/m<sup>2</sup>

Others: -

Pain Score: 0/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale (NRS) / CPOT

Fall Risk Score: 30 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High

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

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☒ No ☐ NA Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet: Normal diet

Drains: Nil

**R**

### RECOMMENDATION

Referral doctors: -

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: -

Critical value alert and its corrections: -

Changes in nursing care plan: ☒ Yes ☐ No. If Yes, modified care plan date: -

Pending follow-up orders: -

Special instructions if any: -

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. Monisha	0441	7/1/24	7:00
Handover taken by		U. Datta	604	7/1/24	7:00
Document endorsed		S. Nalini	0029	7/1/24	10:00

## NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
7/1/24	<u>Admission note</u>	
21:30	pt got Admitted on 1st floor for tomorrow plan for EPS + RFA vital signs checked & Reassessed	[Signature]
22:30	nurses Assessment done	[Signature]
23:30	pt had food medication done, consent was taken up explained	[Signature]
	provided comfortable position pt sleep well	[Signature]
6:30	There is no consent vital signs checked & Reassessed morning care : yes done.	[Signature]
7:30	at hand over to morning duty staff	[Signature]
8:00	<u>shifting notes</u> → patient to day EPS + RFA Plan → patient IV line (P) → patient Anticipation. IIV - caffeine 1g	[Signature]
8:30	gains → NO at AM → patient shifted to cath lab	[Signature]
Document endorsed by	Signature	Name
	[Signature]	S. Alalari
	Emp. No.	0024
	Date	7/1/24
	Time	10:00



## PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 8/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

**S**

### SITUATION

Diagnosis: COPD, pneumonia, S/P CABG, TBM, Hm

NEWS / PEWS Score: 0

Ventilator day: —

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: —

GCS: 15/15

POD: —

Central line days: —

VIP Score: 0/5

**B**

### BACKGROUND

Type of surgery: CI

Date of surgery: —

Allergies if any: penicillin

On room air / oxygen: on room air

IV fluids on flow: —

Complaints / New Symptoms in last shift: N

**A**

### ASSESSMENT

Vital Signs: Temp: 98.4°F | Pulse / HR: 76b/m (beats/min) | Respiration: 20b/m (breaths/min)

BP: 120/80 (mmHg) | SpO<sub>2</sub>: 96 (%) | Height: 176 (cms) | Weight: 78.4 (kgs) | BMI: 25.5 kg/m<sup>2</sup>

Others: —

Pain Score: 1/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☒ Medium ☐ High

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

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☒ No ☐ NA Wound Dressing done: ☐ Yes ☒ No ☐ NA

Current diet: DND diet

Drains: —

**R**

### RECOMMENDATION

Referral doctors: —

Pending medications: —

Pending medication indent: —



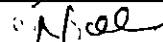
Pending lab reports / Investigations: —

Critical value alert and its corrections: —

Changes in nursing care plan: ☐ Yes ☒ No. If Yes, modified care plan date: —

Pending follow-up orders: —

Special instructions if any: To delay EPS + RPO

	Signature	Name	Emp. No.	Date	Time
Handover given by		H-Dasgupta	0176	8/1/24	8:25
Handover taken by		Baratharaj	0176	8/1/24	8:35
Document endorsed		S. N. Malini	0024	8/1/24	10:00

[illegible]

## PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 8/1/24 Shift: ☐ Morning ☒ Evening ☐ Night

**S**

### SITUATION

Diagnosis: CAD / BPH / s/p CABG (2022) / Tasm / SHTN  
NEWS / PEWS Score: GCS: 15/15  
Ventilator day: POD:  
Peripheral line day: Right: cephalic Left: Metatarsal  
Ryle's Tube: ☐ Yes ☒ No Day:  
Urinary Catheter: ☐ Yes ☒ No Day:  
Barrier nursing: ☐ Yes ☒ No MDR: ☐ Yes ☒ No. If Yes, specify organism:  
Central line days:  
VIP Score: 0/5

**B**

### BACKGROUND

Type of surgery: CABG + BPH + RFA Date of surgery: 8/1/24  
Allergies if any: Inf. Penicillin  
On room air / oxygen: O2 2 L/min fm on flow fluids on flow: IVF NR: 30 c/hr.  
Complaints / New Symptoms in last shift: on flow

**A**

### ASSESSMENT

Vital Signs: Temp: 97.8°F | Pulse / HR: 69 (beats/min) | Respiration: 22 (breaths/min)  
BP: 120/65 (mmHg) | SpO2: 95 (%) | Height: 176 (cms) | Weight: 78.4 (kgs) | BMI: 25.5 kg/m<sup>2</sup>  
Others :  
Pain Score: 0/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT  
Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High  
Braden Score: ☐ Minimal Risk: 23-19 ☒ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6  
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☒ No ☒ NA Wound Dressing done: ☐ Yes ☒ No ☒ NA  
Current diet: Diabetic diet Drains:

**R**

### RECOMMENDATION

Referral doctors:  
Pending medications:  
Pending medication indent:  
Pending lab reports / Investigations:  
Critical value alert and its corrections:  
Changes in nursing care plan: ☐ Yes ☒ No. If Yes, modified care plan date:   
Pending follow-up orders:  
Special instructions if any: plan for discharge tomorrow.

	Signature	Name	Emp. No.	Date	Time
Handover given by	<i>[Signature]</i>	Lalanya	0128	8/1/24	17:50
Handover taken by	<i>[Signature]</i>	Lalanya	0224	8/1/24	19:30
Document endorsed	<i>[Signature]</i>	S. Malini	0024	8/1/24	10:00

## NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.			
8/1/24 @ 13:10	⇒ Patient received from cath lab patient was haemodynamically stable. ⇒ CABG + EP + RFA done Sheath removed. (2) side leg pressure bandage applied. ⇒ vitals connected. stat ECG & ABG taken.	Al 0158.			
14:00	⇒ He had juice & food no vomiting sensation				
✓	⇒ on O <sub>2</sub> support 2 L O <sub>2</sub> via fm on flow.				
14:30	⇒ Due medication given as per chart	Al 0158.			
14:30	⇒ NG stopped @ 14:30 O/S Dr. Talchankar.	Al 0158.			
14:50	⇒ Patient shifted to 1 <sup>st</sup> floor (11A).	Al 0158.			
<u>Recovery Notes</u>					
18:00	Pt Recovery from ECG Pt is stable EPG + RFA done Rt femoral approach pressure bandage (2)	(P) 2557.			
19:30	Pt Handled over to Night Duty RN	(P) 2557			
Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Al	S. Nalini	0024	8/1/24	10:00

## PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 8/1/24

Shift: ☐ Morning ☒ Evening ☐ Night

**S**

### SITUATION

Diagnosis: CAD / BPH / SIP CABG (2022) / T2DM / HTN  
NEWS / PEWS Score: -  
Ventilator day: -  
Peripheral line day: Right: - Left: Metacarpal  
Ryle's Tube: ☐ Yes ☒ No Day: - VIP Score: 0.5  
Urinary Catheter: ☐ Yes ☒ No Day: -  
Barrier nursing: ☐ Yes ☒ No MDR: ☐ Yes ☒ No. If Yes, specify organism: -

**B**

### BACKGROUND

Type of surgery: CABG + BPT + RFA Date of surgery: 8/1/24  
Allergies if any: Penicillin  
On room air / oxygen: on room air  
Complaints / New Symptoms in last shift: -  
IV fluids on flow: DVF -

**A**

### ASSESSMENT

Vital Signs: Temp: 97.8°F | Pulse / HR: 69 (beats/min) | Respiration: 22 (breaths/min)  
BP: 120/60 (mmHg) | SpO<sub>2</sub>: 95% | Height: 170 (cms) | Weight: 78.4 (kgs) | BMI: 22.5 kg/m<sup>2</sup>  
Others: -  
Pain Score: 0/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT  
Fall Risk Score: 50 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High  
Braden Score: ☐ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6  
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA Wound Dressing done: ☐ Yes ☐ No ☒ NA  
Current diet: DM DIET. Drains: -

**R**

### RECOMMENDATION

Referral doctors: -  
Pending medications: -  
Pending medication indent: -  
Pending lab reports / Investigations: Nil  
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: Plan for discharge tomorrow.

	Signature	Name	Emp. No.	Date	Time
Handover given by	Sen	Senipriya	0224	8/1/24	12.20
Handover taken by	Devi	B. Narain	0195	8/1/24	12.30
Document endorsed	Nice	S. Lalitha	0020	8/1/24	10.02

## NURSES PROGRESS NOTES

[illegible]

## PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 9/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

**S**

### SITUATION

Diagnosis:

NEWS / PEWS Score:

Ventilator day:

Peripheral line day: Right:

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

Barrier nursing: ☐ Yes ☒ No

Left:

Day:

Day:

MDR: ☐ Yes ☐ No. If Yes, specify organism:

GCS: 15/15

POD:

Central line days:

VIP Score: 0/5

**B**

### BACKGROUND

Type of surgery:

Allergies if any:

On room air / oxygen:

Complaints / New Symptoms in last shift:

Date of surgery:

IV fluids on flow:

**A**

### ASSESSMENT

Vital Signs: Temp: 92.4°F | Pulse / HR: 82/min (beats/min) | Respiration: (breaths/min)

BP: 120/70 (mmHg) | SpO<sub>2</sub>: 96 (%) | Height: 170 (cms) | Weight: 74.4 (kgs) | BMI: 22.5 kg/m<sup>2</sup>

Others:

Pain Score: Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT

Fall Risk Score: Fall Risk Protocol: ☐ Low ☐ Medium ☐ High

Braden Score: ☒ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6

Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA Wound Dressing done: ☐ Yes ☐ No ☒ NA

Current diet: SOFT DIET

Drains:

**R**

### RECOMMENDATION

Referral doctors:

Pending medications:

Pending medication indent:

Pending lab reports / Investigations:

Critical value alert and its corrections:

Changes in nursing care plan: ☐ Yes ☒ No. If Yes, modified care plan date:

Pending follow-up orders:

Special instructions if any: Today plan D/L

	Signature	Name	Emp. No.	Date	Time
Handover given by		B. Venkatesh	0195	9/1/24	12-30
Handover taken by		IO & Charge			
Document endorsed					

## NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
	<u>Mngg duty Sln Report</u>	
9/1/24		
7.30	⇒ pt is taken over from night duty staff.	Wly over
	⇒ pt is conscious & oriented	
	Vitals are checked & recorded	
8.30	⇒ pt had a food	
	⇒ Sln medication given as per doctor's order.	Wly over
9.00	⇒ Sln Dr. Ganaveli O/B today plan D/S.	
10.00	⇒ Billing card & All Sounded	
	⇒ pt condition stable, vital stable.	Wly over
	⇒ pt false well rest.	
12.00	⇒ Cbg checked & D/S chart maintained.	
	⇒ pt Details Handling over to evening duty staff	Wly over
	<u>Discharge notes</u>	
17.00		
	⇒ Patient stable and Conscious	Hay over
	⇒ patient vital Signs checked and Recorded	
	⇒ Discharge Summary explained	Hay over
	ID band Removed	
	⇒ Iv line Removed	
	⇒ patient got discharged @ 17:30	Hay over
Document endorsed by	Signature	Name
	Nel	S. A. Calini
		Emp. No.
		Date
		Time
		0021, 9/1/24/17.00



## ADULT NURSING CARE PLAN

Mr. VENKATRAMAN SUBRAMAN  
68 / Male / MHI202400005  
07/01/2024 / IPH2024000053  
Dr. K. JAISHANKAR

Initial Date: 7/1/24		Time: 19:00		Modified Date:		Time:	
Reason for Modification:				Diagnosis:			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
<b>NUTRITION</b> <input type="checkbox"/> Keep NPO <input checked="" type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input checked="" type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M				
			E				
			N	pt had diet @ 19:00			
<b>OXYGENATION</b> <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O <sub>2</sub> <input type="checkbox"/> Mask <input type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal O <sub>2</sub> saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O <sub>2</sub> saturation and pulse rate <input type="checkbox"/> If any O <sub>2</sub> abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M				
			E				
			N	SpO <sub>2</sub> = 98%			
<b>FLUID &amp; ELECTROLYTES</b> <input checked="" type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M				
			E				
			N	No chills monitored			

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

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

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
<b>COMMUNICATION</b> <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input type="checkbox"/> Patient will communicate effectively with positive feedback	<input checked="" type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M  E  N <i>not communicate well</i>	  <i>[Signature]</i>
<b>SPECIAL INTERVENTIONS</b> <input type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M  E  N <i>medication was given</i>	  <i>[Signature]</i>
Endorsed by	Signature	Name	Emp. ID	Date	Time
	<i>[Signature]</i>	<i>S. Nalini</i>	<i>0024</i>	<i>7/1/24</i>	<i>10:00</i>

## ADULT NURSING CARE PLAN

Mr. VENKATRAMAN SUBRAMAN  
68/Male/MHI202400005  
07/01/2024/IPH2024000053  
Dr. K. JAISHANKAR

Initial Date: 8/1/24 Time: 08:00		Modified Date: Time:	
Reason for Modification:		Diagnosis: CAD / BPH / DM	
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Sign & Initials
<b>NUTRITION</b> <input type="checkbox"/> Keep NPO <input type="checkbox"/> Regular Diet <input checked="" type="checkbox"/> Others:	<input type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input checked="" type="checkbox"/> Record amount of food consumed	M pt on DM diet
			E patient had lunch
			N pt had DM diet
<b>OXYGENATION</b> <input type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O <sub>2</sub> <input type="checkbox"/> Mask <input checked="" type="checkbox"/> BiPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal O <sub>2</sub> saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O <sub>2</sub> saturation and pulse rate <input type="checkbox"/> If any O <sub>2</sub> abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M pt room air
			E patient on SPO <sub>2</sub> maintained
			N pt on SPO <sub>2</sub> maintained
<b>FLUID &amp; ELECTROLYTES</b> <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M pt electrolytes
			E patient fluid status was balanced
			N pt fluid & electrolyte monitored

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

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
<b>HYGIENE</b> <input type="checkbox"/> Bed-Bath <input type="checkbox"/> Assist-Bath <input type="checkbox"/> Self-Care <input type="checkbox"/> CDD Care (if present) <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will stay clean and well-groomed <input type="checkbox"/> Patient will demonstrate lifestyle changes to meet self-care needs <input type="checkbox"/> Patient will recognize individual weakness or needs	<input type="checkbox"/> Encourage patient to do daily bathing and oral hygiene <input type="checkbox"/> Change patient's gown daily <input type="checkbox"/> Encourage hand hygiene <input type="checkbox"/> Consider the patient's need for assistive devices <input type="checkbox"/> Apply moisturizing solution	M pt will selfw E patient stay cleaned N pt groomed well	[Signature] fl 0158 [Signature]
<b>SAFETY</b> <input type="checkbox"/> Check ID Band <input type="checkbox"/> IV care <input type="checkbox"/> EJV <b>CENTRAL LINE</b> <input type="checkbox"/> Side rails <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have no life-threatening situations	<input type="checkbox"/> Check the identity with ID band before any interaction with the patient <input type="checkbox"/> Raise side rails <input type="checkbox"/> Provide proper invasive line care <input type="checkbox"/> Keep bed locked and low at all time <input type="checkbox"/> Educate care providers to be the patient <input type="checkbox"/> Follow restrain policy (if needed)	M pt ID can E patient ID band N Patient ID band	[Signature] fl 0158 [Signature]
<b>COMFORT AND SLEEP</b> <input type="checkbox"/> Pain Control <input type="checkbox"/> Sleep Patterns <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have comfortable sleep <input type="checkbox"/> Patient will verbalize/ or through behavior about pain relief and adequate sleep	<input type="checkbox"/> Provide clean calm and restful environment <input type="checkbox"/> Provide privacy at all time <input type="checkbox"/> Monitor pain scale / sleep pattern <input type="checkbox"/> Provide pharmacological and non-pharmacological therapy	M pt comfortable sleep E provide privacy N provide comfortable sleep	[Signature] fl 0158 [Signature]
<b>OBSERVATION</b> <input type="checkbox"/> Vital Signs <input type="checkbox"/> GCS <input type="checkbox"/> Blood Sugar <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal range of vital parameters	<input type="checkbox"/> Monitor vital signs regularly <input type="checkbox"/> Monitor vital signs on ordered time <input type="checkbox"/> Assess physically for any abnormality <input type="checkbox"/> Inform doctor if there is any abnormality <input type="checkbox"/> Monitor GCS of patient <input type="checkbox"/> Determine and treat the underlying cause of altered LOC <input type="checkbox"/> Regular blood sugar monitoring as per doctors order	M pt vital signs check E pt vitals stable N pt vitals checked	[Signature] fl 0158 [Signature]
<b>PSYCHOLOGICAL / SPIRITUAL SUPPORT</b> <input type="checkbox"/> Spiritual Needs <input type="checkbox"/> Beliefs / Values / Customs <input type="checkbox"/> Anxiety and Coping Pattern <input type="checkbox"/> Identify Stressors <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will achieve spiritual needs <input type="checkbox"/> Patient will be able to control his feeling toward his illness <input type="checkbox"/> Patient will maintain normal psychological pattern	<input type="checkbox"/> Pray or encourage the patient to pray <input type="checkbox"/> Use inspirational words <input type="checkbox"/> Respond to spiritual needs as they arise <input type="checkbox"/> Evaluate spiritual needs <input type="checkbox"/> Encourage verbalization of feelings / therapeutic touch <input type="checkbox"/> Provide empathy and reassurance	M — E — N —	[Signature] [Signature] [Signature]

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
<b>COMMUNICATION</b> <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input type="checkbox"/> Patient will communicate effectively with positive feedback	<input type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M pt reassured E maintained good rapport N pt communication well	[Signature] [Signature] [Signature]
<b>SPECIAL INTERVENTIONS</b> <input type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input type="checkbox"/> To manage on time	<input type="checkbox"/> Double check for high alert medication <input type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M pt medication given E patient medication given as per chart N pt medication given	[Signature] [Signature] [Signature]
Endorsed by	Signature	Name	Emp. ID	Date	Time
	[Signature]	S. Malini	0024	8/1/24	10:01



# ADULT NURSING CARE PLAN

Mr. VENKATRAMAN SUBRAMAN  
68/Male/MHI202400005  
07/01/2024/IPH2024000053  
Dr. K. JAISHANKAR

Initial Date: 9/1/24		Time: 8:00		Modified Date:		Time:	
Reason for Modification:				Diagnosis: ERS + RFA			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
<b>NUTRITION</b> <input type="checkbox"/> Keep NPO <input checked="" type="checkbox"/> Regular Diet <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have adequate nutrition with no nausea and vomiting <input type="checkbox"/> Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	<input checked="" type="checkbox"/> Provide Prescribed diet on time <input type="checkbox"/> Encourage patient to consume the served meal <input type="checkbox"/> Record amount of food consumed	M pt had Dm diet E N	QJ Star			
<b>OXYGENATION</b> <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O <sub>2</sub> <input type="checkbox"/> Mask <input type="checkbox"/> BIPAP / CPAP <input type="checkbox"/> Ventilator <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have normal O <sub>2</sub> saturation <input type="checkbox"/> Patient ABG levels will return to and remain within normal limits <input type="checkbox"/> No other respiratory abnormalities <input type="checkbox"/> Patient respiratory rate will remain within established limits <input type="checkbox"/> Patient will indicate, either verbally or through behavior, feeling comfortable when breathing	<input checked="" type="checkbox"/> Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises <input type="checkbox"/> Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order <input type="checkbox"/> Utilise pulse oximetry to check O <sub>2</sub> saturation and pulse rate <input type="checkbox"/> If any O <sub>2</sub> abnormalities detected inform immediately to the concerned physician <input type="checkbox"/> Place patient with proper body alignment for maximum breathing pattern <input type="checkbox"/> Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis <input type="checkbox"/> Note for changes in level of consciousness <input type="checkbox"/> Send sputum for culture and sensitivity based on physician order <input type="checkbox"/> Maintain clear airway by suctioning or encouraging patient with successful coughing	M pt on Room Air E N	QJ Star			
<b>FLUID &amp; ELECTROLYTES</b> <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Parenteral Nutrition <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Patient will have balanced fluid and electrolytes balance	<input checked="" type="checkbox"/> Enhance fluid intake unless restricted <input type="checkbox"/> Check IV sites and assess if there is any complication <input type="checkbox"/> Provide tube feedings <input type="checkbox"/> Monitor intake and output <input type="checkbox"/> Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses <input type="checkbox"/> Monitor for possible sources of fluid loss <input type="checkbox"/> Monitor BP for orthostatic changes	M pt <del>maintained</del> fluid maintained E N	QJ Star			

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

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

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
<b>COMMUNICATION</b> <input checked="" type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign language <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> Patient will communicate effectively with positive feedback	<input checked="" type="checkbox"/> Introduce the care giver <input type="checkbox"/> Encourage the use of call bell <input type="checkbox"/> Obtain interpreter if needed <input type="checkbox"/> No negative speaking about the patient's condition or prognosis in the patient's presence	M <i>pt well communicated</i> E N	<i>Al</i> <i>Star</i>
<b>SPECIAL INTERVENTIONS</b> <input checked="" type="checkbox"/> Medication <input type="checkbox"/> Wound care <input type="checkbox"/> Isolation <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Blood / Blood products transfusion <input type="checkbox"/> Fluid tapping <input type="checkbox"/> DVT Management <input type="checkbox"/> Others:		<input checked="" type="checkbox"/> To manage on time	<input checked="" type="checkbox"/> Double check for high alert medication <input checked="" type="checkbox"/> Observe and report any medication reaction <input type="checkbox"/> Provide proper measures of wound care <input type="checkbox"/> Follow hospital policies and protocols of isolation and explain to the patient / family <input type="checkbox"/> Check for cross matching and typing, to ensure compatibility <input type="checkbox"/> Practice strict asepsis while transfusing blood or blood products and fluids <input type="checkbox"/> Monitor DVT score and continue treatment as per doctors order	M <i>Due medication was given</i> E N	<i>Al</i> <i>Star</i>
Endorsed by	Signature	Name	Emp. ID	Date	Time
	<i>Nal</i>	<i>S. Malini</i>	<i>0024</i>	<i>9/1/04</i>	<i>10.00</i>

## BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

<b>SENSORY PERCEPTION</b> ability to respond meaning-fully to pressure-related discomfort	<b>1. Completely Limited</b> 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	<b>2. Very Limited</b> 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	<b>3. Slightly Limited</b> 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	<b>4. No Impairment</b> Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort		-	4
<b>MOISTURE</b> degree to which skin is exposed to moisture	<b>1. Constantly Moist</b> Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	<b>2. Very Moist</b> Skin is often, but not always moist. Linen must be changed at least once a shift	<b>3. Occasionally Moist</b> Skin is occasionally moist, requiring an extra linen change approximately once a day	<b>4. Rarely Moist</b> Skin is usually dry, linen only requires changing at routine intervals			4
<b>ACTIVITY</b> degree of physical activity	<b>1. Bedfast</b> Confined to bed	<b>2. Chairfast</b> Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	<b>3. Walks Occasionally</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	<b>4. Walks Frequently</b> Walks outside room at least twice a day and inside room at least once every two hours during waking hours			4
<b>MOBILITY</b> ability to change and control body position	<b>1. Completely Immobile</b> Does not make even slight changes in body or extremity position without assistance	<b>2. Very Limited</b> Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	<b>3. Slight Limited</b> Makes frequent through slight changes in body or extremity position independently	<b>4. No Limitation</b> Makes major and frequent changes in position without assistance			4
<b>NUTRITION</b> usual food intake pattern	<b>1. Very Poor</b> 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 IVs for more than 5 days	<b>2. Probably Inadequate</b> Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	<b>3. Adequate</b> Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	<b>4. Excellent</b> Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation			4
<b>FRICTION &amp; SHEAR</b>	<b>1. Problem</b> 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	<b>2. Potential Problem</b> 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	<b>3. No Apparent Problem</b> 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
				<b>TOTAL SCORE</b>			23
				<b>Initial &amp; Emp. No. of Staff Nurse:</b>			24/1
				<b>Initial &amp; Emp. No. of Sr. Staff Nurse:</b>			10/1

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

## BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

<b>SENSORY PERCEPTION</b> ability to respond meaningfully to pressure-related discomfort	<b>1. Completely Limited</b> Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation <b>OR</b> limited ability to feel pain over most of body	<b>2. Very Limited</b> Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness <b>OR</b> has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	<b>3. Slightly Limited</b> Responds to verbal commands, but cannot always communicate discomfort or the need to be turned <b>OR</b> had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	<b>4. No Impairment</b> Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	4
<b>MOISTURE</b> degree to which skin is exposed to moisture	<b>1. Constantly Moist</b> Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	<b>2. Very Moist</b> Skin is often, but not always moist. Linen must be changed at least once a shift	<b>3. Occasionally Moist</b> Skin is occasionally moist, requiring an extra linen change approximately once a day	<b>4. Rarely Moist</b> Skin is usually dry, linen only requires changing at routine intervals	4	4	4
<b>ACTIVITY</b> degree of physical activity	<b>1. Bedfast</b> Confined to bed	<b>2. Chairfast</b> Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	<b>3. Walks Occasionally</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	<b>4. Walks Frequently</b> Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	2	1
<b>MOBILITY</b> ability to change and control body position	<b>1. Completely Immobile</b> Does not make even slight changes in body or extremity position without assistance	<b>2. Very Limited</b> Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	<b>3. Slight Limited</b> Makes frequent through slight changes in body or extremity position independently	<b>4. No Limitation</b> Makes major and frequent changes in position without assistance	4	2	2
<b>NUTRITION</b> usual food intake pattern	<b>1. Very Poor</b> 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 <b>OR</b> Is NPO and / or maintained on clear liquids or IV's for more than 5 days	<b>2. Probably Inadequate</b> Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	<b>3. Adequate</b> Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered <b>OR</b> Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	<b>4. Excellent</b> Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	4	3	3
<b>FRICION &amp; SHEAR</b>	<b>1. Problem</b> 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	<b>2. Potential Problem</b> 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	<b>3. No Apparent Problem</b> 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	3
				<b>TOTAL SCORE</b>	22	17	17
				<b>Initial &amp; Emp. No. of Staff Nurse:</b>	8	11	11

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







## BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

<b>SENSORY PERCEPTION</b> ability to respond meaningfully to pressure-related discomfort	<b>1. Completely Limited</b> 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	<b>2. Very Limited</b> 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	<b>3. Slightly Limited</b> 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	<b>4. No Impairment</b> Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4		
<b>MOISTURE</b> degree to which skin is exposed to moisture	<b>1. Constantly Moist</b> Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	<b>2. Very Moist</b> Skin is often, but not always moist. Linen must be changed at least once a shift	<b>3. Occasionally Moist</b> Skin is occasionally moist, requiring an extra linen change approximately once a day	<b>4. Rarely Moist</b> Skin is usually dry, linen only requires changing at routine intervals	4		
<b>ACTIVITY</b> degree of physical activity	<b>1. Bedfast</b> Confined to bed	<b>2. Chairfast</b> Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	<b>3. Walks Occasionally</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	<b>4. Walks Frequently</b> Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4		
<b>MOBILITY</b> ability to change and control body position	<b>1. Completely Immobile</b> Does not make even slight changes in body or extremity position without assistance	<b>2. Very Limited</b> Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	<b>3. Slight Limited</b> Makes frequent through slight changes in body or extremity position independently	<b>4. No Limitation</b> Makes major and frequent changes in position without assistance	3		
<b>NUTRITION</b> usual food intake pattern	<b>1. Very Poor</b> 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 IVs for more than 5 days	<b>2. Probably Inadequate</b> Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	<b>3. Adequate</b> Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	<b>4. Excellent</b> Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	3		
<b>FRICTION &amp; SHEAR</b>	<b>1. Problem</b> 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	<b>2. Potential Problem</b> 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	<b>3. No Apparent Problem</b> 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		
					<b>TOTAL SCORE</b>	21	
					<b>Initial &amp; Emp. No. of Staff Nurse:</b>	21	
					<b>Initial &amp; Emp. No. of Sr. Staff Nurse:</b>	21	

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



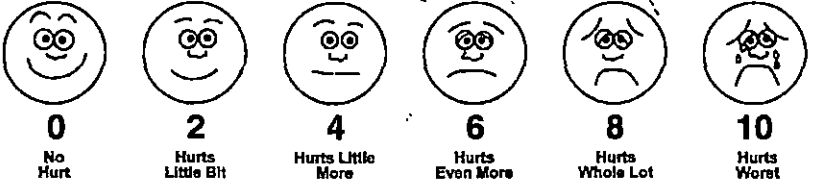
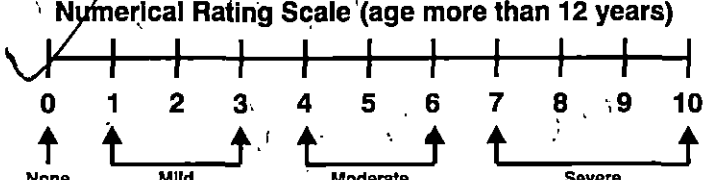
# PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
7/1/24 09:00	0/10	no pain	-	-	-		
09:30	0/10	no pain	-	-	-		
8/1/24 3:30	0/10	no pain	-	-	-		
4:30	0/10	no pain	-	-	-		
11:00		Patient received @ 13:10.					
13:10	0/10	No pain	-	-	-	AL 0158	Jaishankar 0001
14:00	0/10	No pain	-	-	-	AL 0158	Jaishankar 0001
15:00	0/10	No pain	-	-	-	AL 0158	Jaishankar 0001
16:00	0/10	No pain	-	-	-	AL 0158	Jaishankar 0001



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.
17:00	0/10	No pain	—	—	—	fl Buss	Jeff 0001
20:00	0/10	No pain	—	—	—	Sen on	Nae 0024
22:00	0/10	No pain	—	—	—	Sen on	Nae 0024
6:00	0/10	No pain	—	—	—	Sen on	Nae 0024

### PAIN SCALES

<b>PIPPS</b> (28 weeks to ≤ 38 weeks)	6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures >12 = Moderate to severe pain - Pharmacological intervention	
<b>CRIES</b> (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.	
<b>FLACC Scale</b> (2 months - 7 years)	0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both	
<b>Wong-Baker FACES Pain Rating Scale</b> (7 years - 12 years)		<b>Numerical Rating Scale (age more than 12 years)</b> 
<b>Critical care Pain Observation Tool (CPOT)</b> (ventilator / comatose)	<b>FACIAL EXPRESSION:</b> 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing <b>BODY MOVEMENTS:</b> 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation <b>COMPLIANCE WITH VENTILATION (Intubated patients):</b> 0 - Tolerating Ventilator or Movement, 1 - Coughing but tolerating, 2 - Fighting ventilator (or) <b>VOCALIZATION (non-Intubated patients):</b> 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing <b>MUSCLE TENSION:</b> 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid <b>TOTAL SCORE:</b> 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain	
<b>Non-pharmacological Interventions</b>	<b>Distraction:</b> A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers <b>Cutaneous Stimulation and massage:</b> E - Positioning; F - Rubbing / Massage the skin <b>Thermal Therapies</b> (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy <b>Transcutaneous electrical nerve stimulation (TENS):</b> J - Interferential therapy   <b>Psycho-social therapy/counseling:</b> K - Individual Counseling; L - Family counseling	

Pharmacological Interventions as per doctor's prescription



**THE UNIVERSITY OF CHICAGO**



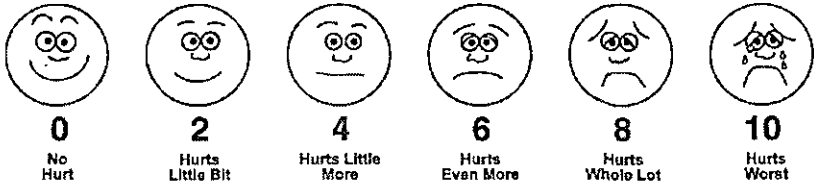
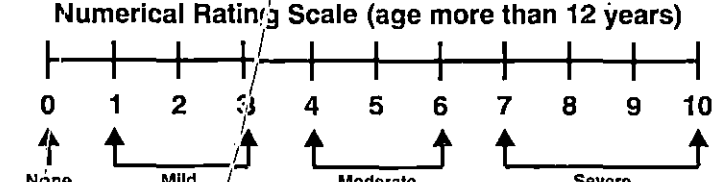
Medway  
**Heart**  
Institute

## Every heart beat counts

[illegible]

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.

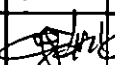
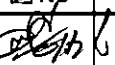
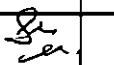
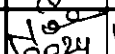
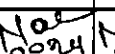
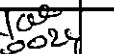
### PAIN SCALES

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<b>Wong-Baker FACES Pain Rating Scale</b> (7 years - 12 years)	<div>  </div> <div> <b>Numerical Rating Scale (age more than 12 years)</b>   </div>
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Pharmacological Interventions as per doctor's prescription

## 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	Time					
		7/1/24	7:20	9:00				
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0				
2	Bedridden recently >3 days or major surgery within four weeks	0	0	0				
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0				
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0				
5	Entire leg swollen (Assess for both legs)	0	0	0				
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0				
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0	0				
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	0				
9	Previously documented DVT (Assess for both legs)	0	0	0				
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	0	0				
FINAL SCORE		0	0	0				
Low Risk: -2 to 0   Moderate Risk: 1 to 2   High Risk: 3 to 8		Low	Low	Low				
DVT prophylaxis started		<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature & Emp. No. of RN								
Signature & Emp. No. of Sr. RN								



**Medway Hospitals**<sup>®</sup>  
The way to better health  
(A Unit of United Alliance Healthcare Pvt Ltd)



MHI/NUR/2022/046

Mr. VENKATRAMAN SUBRAMAN

68/Male/MHI202400005

07/01/2024/IPH2024000053

Dr. K. JAISHANKAR



## MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	7/1/24	8/1/24	8/1/24	8/1/24	9/1/24				
	Time	19:20	8:00	13:10	20:00	8:00				
History of falling (immediate or within 6 months)	No	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
<b>AMBULATORY AID</b>										
None / Bed Rest / Nurse Assist		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
<b>GAIT</b>										
Normal / Bed Rest / Wheel Chair		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
<b>MENTAL STATUS</b>										
Oriented to own stability		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
<b>MEDICATIONS</b> Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	<input checked="" type="checkbox"/>	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
<b>Total Score</b>		30	30	30	30	30				
<b>Low Risk (0 - 24)</b>										
<b>Medium Risk (25 - 44)</b>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>				
<b>High Risk (45 or above)</b>				<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>				
<b>Signature &amp; Emp. No. of RN</b>										
<b>Signature &amp; Emp. No. of Sr. RN</b>										

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

INTERVENTIONS <i>Tick as per the Risk Score</i>	Date	Time							
	7/1/24	8:00	8:00	8:15	8:15	8:15	8:15	8:15	8:15
<b>Low Risk Interventions (0 - 24)</b>									
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	✓	✓	✓	✓	✓				
<b>Medium risk interventions (25 - 44)</b>									
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	✓	✓	✓	✓	✓				
<b>High-risk interventions (45 or above)</b>									
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			NA	NA	NA				
If appropriate, consider using protection devices: safety belts	✓	✓	✓	✓	✓				
<b>Signature &amp; Emp. No. of RN</b>	1700	1700	1700	1700	1700				
<b>Signature &amp; Emp. No. of Sr. RN</b>	1700	1700	1700	1700	1700				

## PATIENT AND FAMILY EDUCATION RECORD

## Assessment

**To be filled by concerned disciplines. Use key below**

Barriers to Learning		Plan to Address Factors
<input checked="" type="checkbox"/> None	<input type="checkbox"/> Vision / Hearing limitations	<input type="checkbox"/> Use of Interpreter
<input type="checkbox"/> Limited Reading Abilities	<input type="checkbox"/> Physical barriers	<input type="checkbox"/> Educate family
<input type="checkbox"/> Religious / Cultural Factors	<input type="checkbox"/> Language barriers	<input type="checkbox"/> Simple Language
<input type="checkbox"/> Cognitive Limitations - unable to understand and follow directions	<input type="checkbox"/> Low motivation / desire to learn	<input type="checkbox"/> Written Instructions
Completed By : Date <u>11/1/11</u> Time <u>9:00</u>		Nurse Signature : <u>[Signature]</u>

## Learning Record

[illegible]

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Nutritional Guidance													Dietician
<input checked="" type="checkbox"/> Diet Instruction for patients at Nutritional risk													Maia C. [Signature] Senior Dietician
<input checked="" type="checkbox"/> Diet advice for home													Nurse
Discharge Planning													
<input type="checkbox"/> Self care													
<input type="checkbox"/> Follow up													
<input type="checkbox"/> Reporting Concerns Immunizations													
<input type="checkbox"/> Parenting education													
<input type="checkbox"/> Others													
Risk Factor Reduction													
<input type="checkbox"/> Smoking Cessation													Doctor
<input type="checkbox"/> Weight Control													
<input type="checkbox"/> Exercise													
<input type="checkbox"/> Hypertension													
<input type="checkbox"/> Other Risks													

LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other \_\_\_\_\_ (State Relationship)

PROCESS (P)- OD - Oral Discussion, D- Demonstration, W- Written Material

OUTCOME (O) - RD - Return Demonstration, V - Verbalized Understanding

Written Material given and explained (if any)

Reports Given :

	Given	Pending	NA		Given	Pending	NA
Discharge Summary	✓			Diet Advice	✓		
ECG Report	✓			CT Scan Report			✓
Doppler Report			✓	CT Scan Film			✓
X-Ray Report	✓			ECHO Report	✓		
X-Ray Film	✓			Ultrasound Report			
Compact Disk		✓		Any Other Report			

Name of Attendant / Patient : VENKATARAMAN SURESH Signature : [Signature]

Name of Discharge Nurse : Hannah Grace Signature : [Signature]



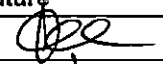


## Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 7/1/24

Time: 19:50

Checklist	Yes	No	NA	Action / Remarks
<b>MEDICAL</b>				
Daily Consultant Visit	/			
Plan of care discussed	/			
Discharge Planning				
Others if any				
<b>NURSING</b>				
Safety Precautions Ensured	/			
Care of Lines and Tubes	/			
Infection Control Measures				
Skin Care				
Response to assistance				
Others if any				
<b>DIETICIAN</b>				
Diet Adequate	/			
Special Request	/			
<b>PHYSIOTHERAPIST</b>				
Available for Assistance for Activities of Daily Living				
Others if any				
<b>PATIENT CARE SERVICES</b>				
Room Cleaning satisfactory				
Room Amenities Adequate				
Billing Update available				
Non-Availability of any service				
Spiritual Needs (if yes specify)				
Others if any				

### Inter Disciplinary Team Members

	Signature	Name	Reg. / Emp. No.	Date	Time
Doctor		Dr. M. S. Srinivasan	16008	7/1/24	20:00
Nursing Staff		A. Monisha	0141	7/1/24	19:50
Dietician		Maria Catherine John Senior Dietitian	2421	7/1/24	19:50
Physiotherapist					
Patient Care Service Staff					

## IN-HOUSE TRANSFER FORM

### Part A (to be filled by Nurses)

Date of Transfer: 8/1/24 Time: 14:50 Transferred from: CCU To: 114 (floor)

Diagnosis:

SIx-CABG: BxH

Vital Signs: Temp: 101.5 (°F) | Pulse / HR: 60 (beats/min) | BP: 120/85 (mmHg) | Respiration: 24 (breaths/min)

### Part B (to be filled by Physicians)

Any Critical Investigations:



Check for	Transferring Doctor	Receiving Doctor
Respiratory (Breath sounds)	<input checked="" type="checkbox"/> Clear <input type="checkbox"/> Crepitation <input type="checkbox"/> Rhonchi <input type="checkbox"/> Others: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Abdomen	<input checked="" type="checkbox"/> Soft <input type="checkbox"/> Tender <input type="checkbox"/> Distended <input type="checkbox"/> Others: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Heart Sound	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Feeble <input type="checkbox"/> Loud <input type="checkbox"/> Others: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
CNS	<input checked="" type="checkbox"/> Conscious <input type="checkbox"/> Oriented GCS Score: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
For Surgical Patients (if applicable)	Surgical Site: <input type="checkbox"/> Healthy <input type="checkbox"/> Soakage <input type="checkbox"/> Others: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

### Present Medication (for Medication Reconciliation)

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
1)	T. SGLXEN-XL	25mg	PO	100	8/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2)	T. Rozavel	10mg	PO	100	7/1/24 @ 20:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3)	T. CORDARONE	200mg	PO	100	7/1/24 @ 20:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4)	T. Pns	40mg	PO	100	8/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5)	T. CREMOLAX	10mg	PO	100	8/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6)	C. Bexoral	1mg	PO	100	8/1/24 @ 8:00	<input type="checkbox"/> Yes <input type="checkbox"/> No
7)	T. Lactulose	10mg	PO	100	8/1/24 @ 8:00	<input type="checkbox"/> Yes <input type="checkbox"/> No
8)	T. CREMOLAX	10mg	PO	100	8/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9)	T. CIVOCAN	10mg	PO	100	8/1/24 @ 8:00	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10)	T. DEFLATT	25mg	PO	100	8/1/24 @ 14:00	<input type="checkbox"/> Yes <input type="checkbox"/> No
11)	T. ELIGUS	2.5mg	PO	100	(Start from tomorrow)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
12)	T. Dolo	600mg	PO	100	8/1/24 @ 14:00	<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

**Additional Details (if any):**

**Patient Condition:** ☒ Stable ☐ Sick-need urgent care ☐ Others: \_\_\_\_\_

	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor		Dr. G. A. Dethlefsen	91810	2/1/24	17.50
Receiving Doctor		Dr. Sigith R.	183073	8/1/24	6:00


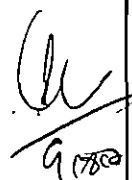
**Part C (to be filled by Nurses)**

Check for	Transferring Nurse	Receiving Nurse
Drains	<input type="checkbox"/> Chest <input type="checkbox"/> Abdominal <input type="checkbox"/> Others: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory	Air Way Type: <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Others: _____ Oxygen Therapy: <input type="checkbox"/> No <input type="checkbox"/> Yes via: <u>Room air</u> , Rate: _____ li/min	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
NG Tube / Oral	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> For Feeding <input type="checkbox"/> Gastric Suction <input type="checkbox"/> Fluid Restriction	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Foley's Catheter	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Intravenous Access	<input checked="" type="checkbox"/> Peripheral Line <input type="checkbox"/> Central Venous Line <input type="checkbox"/> Others: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Pressure Injury	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, give details: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Score	Fall Risk: <u>50</u> WELLS: _____ NEWS / PEWS: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Patient Belongings	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, give details: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Handover Details	Medication Administration Record explained: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Lab & Diagnostic Reports handed over: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Patient Attendant Informed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, give details: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Additional Details (if any):

	Sign.	Name	Emp. No.	Date	Time
Transferring Nurse	<i>[Signature]</i>	Laranga.	0078	8/1/24	17:50
Receiving Nurse	<i>[Signature]</i>	<i>[Signature]</i>	0072	8/1/24	17:55

## FAMILY COUNSELLING FORM

CONSULTANT- Dr. Jaishankar.			DIAGNOSIS- CAD / BPH / T2DM / SHH N.			
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
8/1/24	DOCTOR	WIFE	pt condition explained to family			 9/1/24

**VIP SCALE (VISUAL INFUSION PHLEBITIS)**

PATIENT NAME : **Mr. VENKATRAMAN SUBRAMAN**  
68/Male/MHI202400005  
07/01/2024/IPH2024000053  
AGE / SEX : **Dr. K. JAISHANKAR**

IP No. / UHID No

Ward / Bed No. **114**

ANY SCORE > 0 SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
8/1/24	8:00	Cubital	0/0	patent	flushed	-	CS/011
	13:10	① Cephalic	0/5	Patent	flushed	followed	TH/058
	20:00	Cubital	0/5	patent	flushed	-	CS/011
9/1/24	8:00	① Cubital	0/5	patent	fluid	Healthy	CS/011
				Line Removed			
8/1/24	9:00	① Metacarpal	0/0	patent	flushed	-	CS/011
	13:10	① Metacarpal	0/5	patent	flushed	followed	TH/058
	20:00	① Metacarpal	0/5	Patent	flushed	followed	TH/058
		① Metacarpal		Line Removed			

`4ARM/2022/028



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



MR. VENKATRAMAN SUBRAMAN

68/Male/MH1202400005

07/01/2024/IPH2024000053

Dr.K.JAISHANKAR



## ALLERGY



**Medway**  
**Heart**  
Institute

## Heart beat counts

# MEDICATION ADMINISTRATION RECORD

**Drug Chart:**

of

of

**Height (cms):**

**Weight (kg):**

**KNOWN MEDICINE ALLERGIES** (if NONE is confirmed, write NKDA in box 1)

Drug Details		Description of Allergy		Doctor's Sign:					
Penicillin Allergy		Penicillin Allergy		Name: <u>DR. SUGATHA B</u> Reg. No. <u>18307</u>					
DOCTOR INSTRUCTIONS		NURSING STAFF INSTRUCTIONS							
1. Use generic name when prescribing drug 2. Write in BLOCK LETTERS, clearly and legibly 3. Sign and enter MCI registration no. or apply seal 4. No prescription should be altered / overwritten 5. Use 24-hour format when writing time		1. Check entries in every section to avoid omissions 2. Nurse in-charge should verify drug chart on daily basis 3. For new prescription, follow the timings of doctor's prescription on Day 1 only, and then follow standard timings 4. Standard Timings: Q24hly: 10:00hrs, Q12hly: 10:00hrs, 22:00hrs or 06:00hrs, 18:00hrs, Q8hly: 06:00hrs, 14:00hrs, 22:00hrs or 09:00hrs, 14:00hrs, 21:00hrs, Q6hly: 05:00hrs, 11:00hrs, 17:00hrs, 23:00hrs, Q4hly: 02:00hrs, 06:00hrs, 10:00hrs, 14:00hrs, 18:00hrs, 22:00hrs							
Stat / Once Only / Premedication Drugs									
Date	Time	Drug	Dose	Route	Doctor		Administered		
					Sign.	Reg. No.	Sign.	Emp. No.	Time
8/1/24	8:15 AM	Drug Sulfagreat	1gm	ID	[Signature]	168802	[Signature]	0182	8-15 AM
8/1/24	8:15 AM	Drug Sulfagreat	1gm	IV	[Signature]	168802	[Signature]	0182	8-15 AM
8/1/24	10:40	INT: HEPARIN	1000	IV	[Signature]		[Signature]	0176 / 0016	10:40
8/1/24	11:20	INT: HEPARIN	1000	IV	[Signature]	97241	[Signature]	0176 / 0016	11:20
8/1/24	11:30	INT: PENTANYL	2mg	IV	[Signature]		[Signature]	0176 / 0016	11:30
8/1/24	11:30	INT: EMESET	4mg	IV	[Signature]		[Signature]	0176	11:30



Clinical Pharmacist  
Midway Heart Institute

Clinical Pharmacist  
Midway Heart Institute

Clinical Pharmacist  
Midway Heart Institute

Clinical Pharmacist  
Midway Heart Institute

REGULAR PRESCRIPTIONS To be filled in by Doctors only			Date →	To be filled by Nursing Staff only. Sign and time given			
			Time ↓				
<b>DRUG NAME</b> C-BECOSULES			8:00	4/1/24	8/1/24	9/1/24	
Dose 1 tab	Route p/o	Frequency 1-0-0					
Dr. Sign & Reg. No. / Seal RD 183573		Start Date & Time 7/1/24					
		Stop Date & Time					
Additional Info:							
<b>DRUG NAME</b> T. Lasiladone			8:00				
Dose 1 tab	Route p/o	Frequency 1/2-0-0					
Dr. Sign & Reg. No. / Seal RD 183573		Start Date & Time 7/1/24					
		Stop Date & Time					
Additional Info:							
<b>DRUG NAME</b> T. DIZPLATE A			14:00				
Dose 754	Route p/o	Frequency 0-1-0					
Dr. Sign & Reg. No. / Seal RD 183573		Start Date & Time 7/1/24					
		Stop Date & Time 8/1/24 @ 13:00					
Additional Info:							
<b>DRUG NAME</b> T. URIMAX D			8:00				
Dose 1 tab	Route p/o	Frequency 1-0-0					
Dr. Sign & Reg. No. / Seal RD 165877		Start Date & Time 7/1/24					
		Stop Date & Time					
Additional Info:							
<b>DRUG NAME</b> T. LIVOGEN			8:00				
Dose 1 tab	Route p/o	Frequency 1-0-0					
Dr. Sign & Reg. No. / Seal RD 165877		Start Date & Time 7/1/24					
		Stop Date & Time					
Additional Info:							
Area In-charge Nurse Signature:							



Clinical Pharmacist  
Medway Heart Institute

Clinical Pharmacist  
Medway Heart Institute

Clinical Pharmacist  
Medway Heart Institute

Clinical Pharmacist  
Medway Heart Institute

Clinical Pharmacist  
Medway Heart Institute

REGULAR PRESCRIPTIONS To be filled in by Doctors only			Date →	To be filled by Nursing Staff only. Sign and time given.			
			Time ↓				
DRUG NAME TAB. DEPLATT							
Dose 75mg	Route PO	Frequency OD.	14:00	14:30	14:00		
Dr. Sign & Reg. No. / Seal Dr. G. Chankar. 49448.		Start Date & Time 08/01/24 @ 13:10					
		Stop Date & Time					
Additional Info:							
DRUG NAME TAB. ELIUS			8:00	→	9:00		
Dose 2.5mg	Route PO	Frequency BD.					
Dr. Sign & Reg. No. / Seal Dr. G. Chankar. 49448		Start Date & Time 09/01/24 @ 13:10					
		Stop Date & Time					
Additional Info:			8 PM				
DRUG NAME T. DOLLO			8:00	→	8:50		
Dose 650mg	Route PO	Frequency 1-2-7 x 3d	14:00	14:30	14:00		
Dr. Sign & Reg. No. / Seal [Signature]		Start Date & Time 8/1/24 @ 13:20	20:00	20:00	20:00		
		Stop Date & Time					
Additional Info:							
DRUG NAME T. PLAVENON-MR			8:00	→	8:50		
Dose 35mg	Route PO	Frequency 1-0					
Dr. Sign & Reg. No. / Seal [Signature]		Start Date & Time 8/1/24					
		Stop Date & Time					
Additional Info:			20:20	20:00	20:00		
DRUG NAME F. MITROCONTIN			8:00	→	8:50		
Dose 2.6mg	Route PO	Frequency 1-0					
Dr. Sign & Reg. No. / Seal [Signature]		Start Date & Time 8/1/24 at 13:30	16:00	16:00	16:00		
		Stop Date & Time					
Additional Info:							
Area In-charge Nurse Signature:							

**REGULAR PRESCRIPTIONS**

To be filled in by Doctors only

Date →

To be filled by Nursing Staff only. Sign and time given

Time ↓

8/1/24

7/1/24

**DRUG NAME**

T-A LPRAX.

Dose

0.25g

Route

PO

Frequency

QD

Dr. Sign &amp; Reg. No. / Seal

RB  
183573

Start Date &amp; Time

8/1/24

Stop Date &amp; Time

Additional Info:

20/20

80-100  
50**DRUG NAME**

Dose

Route

Frequency

Dr. Sign &amp; Reg. No. / Seal

Start Date &amp; Time

Stop Date &amp; Time

Additional Info:

**DRUG NAME**

Dose

Route

Frequency

Dr. Sign &amp; Reg. No. / Seal

Start Date &amp; Time

Stop Date &amp; Time

Additional Info:

**DRUG NAME**

Dose

Route

Frequency

Dr. Sign &amp; Reg. No. / Seal

Start Date &amp; Time

Stop Date &amp; Time

Additional Info:

**DRUG NAME**

Dose

Route

Frequency

Dr. Sign &amp; Reg. No. / Seal

Start Date &amp; Time

Stop Date &amp; Time

Additional Info:

Area In-charge

Nurse Signature:

100  
50

## PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD

[illegible]



CU-14:20

## IP No. :

DOA : 8/1/24

UHID No. :

Room No. : (001)

[illegible]**Pharm Bill & Name**

MHI/ICU/2022/064



**The way to**  
(A Unit of United A

Mr. VENKATRAMAN SUBRAMAN

68/Male/MHI202400005

07/01/2024/IPH2024000053

Dr.K.JAISHANKAR



## Every heart beat counts

## IMMEDIATE CARE FLOWCHART

**A**

UHID NO : 204400005 AGE : 68 yrs SEX : Male

**SURGICAL PROCEDURE:** EP + RFA.

POSTOP DAY : 30

**FLUID REQUIREMENT :** —

$$81|_{24} \rightarrow C$$
[illegible]



**The way to be**  
(A Unit of United Alliance)

68/Male/MHI202400005

07/01/2024/IPH2024000053

Dr.K.JAISHANKAR



Medway  
**Heart**  
Institute

## Every heart beat counts

**B**

UHID NO: 20400005 AGE: 68 yrs. SEX: 68 yrs/male.

HEIGHT : 176 cm

WEIGHT: 78.6 kg

B.S.A:  $1.4 \text{ m}^2$

8/1/24 → ①

[illegible]