



MRD CHECKLIST

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



Medway Hospitals

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



Mr. SRIRAM BABU
P: 35/Male/MHI202481674
N 08/01/2024/IPH2024000063
Dr. G. GNANAVELU
Consultant:

MHI/IPD/2022/002



Every heart beat counts

ADMISSION SLIP

Admitting Doctor:

Dr. Gnanavelu / Dr. Sampath Kumar
Speciality: Cardiology

Advised Date & Time:

8/1/24 @ 10:57 AM

Provisional Diagnosis:

HTN / sm / Atypical chest pain / ? new onset

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):

CAC

Blood Product Requirement:

☒ No

☐ Yes

(Kindly specify details of components required in space below)

Expected Duration of Stay:

Day Care

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

Payer:

☐ Self

☒ Insurance

☐ Others:

Instructions to Nurse (if any):

Admission in OP

Any other Instructions (if any):

16000 -/-

Signature

Name Dr. G. Gnanavelu MD, DM (Cardiology), FACC

Reg. No.

Date

Time

Chief Cardiologist

Reg. No: 39469

8/1/24

10:57 AM

For admission desk staff only:

Room Category: ☐ General Ward

☐ Single Room

☐ Twin Sharing

☐ Deluxe Room

☐ Suite Room

☒ Others PL

Admission intimation Receipt Details

Admission Time in HIS

Date

Time

Date

Time

08/01/24

11:18 A.M

08/01/24

11:18 AM

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

[Signature]

Jeshma banu

MH10264

08/01/24

11:18 A.M

ADMISSION FORM

Marital Status M	Full Address Q209 & Q210, Q Block, Tshayara Apartments, Vadakkupattu Main Road, Medayyankan, Chennai		Telephone Number 9788504168
Occupation PL			
Referred from Dr. UMANA VELU	Date of Time of Admission 08/01/24 @ 11:15 AM	Date & Time of Discharge 8/1/24 @ 13:55	Total No. of Days Thrs 35 mths.
UNIT PL	MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes AR No. :		
FINAL DIAGNOSIS			ICD Code
ATYPICAL - CHEST PAIN			R07.4
TMT - POSITIVE (07.2024)			
NORMAL LV FUNCTION			I50.1
SYSTEMIC HYPERTENSION			I10
24 SLIPIDE HIA			
DATE	OPERATION / PROCEDURES		ICPM Code
9/1/24	CORONARY ANGIOGRAM.		
DATE	TYPE OF ANESTHESIA		
9/1/24	<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 [Signature]		Signature of Medical Records Officer S. Alen Sa 2508	

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....SPINAM RAJU who is myHUSBAND..... (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 their attendants have been removed to a place of safety / handed over to the next of kin and I absolve the hospital of any responsibility with regard to any loss.

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

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

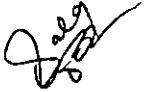
இதன் மூலமாக நான் நிர்வாகம், மருத்துவம், தாதியர், ஏனைய மருத்துவ ஊழியர்கள் எனக்கு / நோயாளிக்கு தேவைப்பட்ட சோதனைகளை செய்து மருந்துகளை கொடுக்கவும், மயக்க மருந்துகள் கொடுத்து செய்முறைகள்/அறுவை சிகிச்சை செய்யவும் அதிகாரம் வழங்குகிறேன். நான் / இதில் குறித்துள்ள நோயாளின் செலவுக்கான தொகை முழுவதும் செலுத்த இதன்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

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

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கப்பட்டிருக்கிறேன்.

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

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.



செவிலியர் கையொப்பம்

Signature of Admitting Nurse

தேதி

Date

05/01/2024



எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of the Patient / Relative / Gurdian

உறவுமுறை wife

Nature of Relationship



Patient Details (Affix Label here)	
Na	Mr. SRIRAM BABU
UH	35/Male/MHI202481674
DO	08/01/2024/IPH2024000063
DC	Dr. G. GNANAVELU
Co	

GENERAL CONSENT FOR ADMISSION


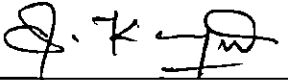
I, SRIRAM BABU the ☒ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ 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			8/1/24	11:18 AM
Surrogate/Guardian (if applicable #)		Karunya (wife) (Write name and relationship with patient)	8/1/24	11:18 AM
Reason for surrogate consent	Patient is unable to give consent because:			
Witness	S. Rajeswari	S. Rajeswari	8/1/24	11:18 AM
Interpreter (if applicable)				

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



JCI ACCREDITED



NABH ACCREDITED



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

DAY CARE DISCHARGE SUMMARY

IP No.	IPH2024000063	D.O.A	: 08/01/2024
UHID	MHI202481674	D.O.P	: 08/01/2024
Name	Mr. SRIRAM BABU	Room No.	: RL
Age / Gender	35 Years / MALE		
Consultant	Dr. G. Gnanavelu. MD., DM., (cardio) FACC Chief Cardiologist	D.O.D	: 08/01/2024
	Dr. Sampath Kumar MD., DM., (cardio)	D.O.D	: 08/01/2024

DIAGNOSIS:

ATYPICAL CHEST PAIN

TMT – POSITIVE (07.2024)

NORMAL LV FUNCTION

SYSTEMIC HYPERTENSION

DYSLIPIDEMIA

PROCEDURE: CORONARY ANGIOGRAM DONE ON 08.01.2024 – MINIMAL CORONARY ARTERY DISEASE.

BRIEF HISTORY:

Mr. Sriram Babu, 35years old male, presented with complaints of chest pain on and off. He was advised Coronary angiogram and referred to Medway Heart Institute on 08.01.2024 for which he has been admitted.

ON EXAMINATION:

R: 84bpm ; BP: 125/83mmHg ; SPO₂: 99% in room air
CVS: S1S2+ ; RS : Clear ; CNS: NFND; Abd: Soft

INVESTIGATIONS:

BLOOD: Hb- 12.2gm/dl, TWBC – 8300 cells / cumm, PLT – 2.16 Lakhs/cumm, Urea – 18.9mg/dl, Creatinine – 1.08mg/dl, Na+ -142.9 meq/l, K+- 3.8 meq/l, INR – 0.97.

ECG: Sinus rhythm, HR @ 100bpm, within normal limits.

ECHO(out side): No RWMA. Normal LV systolic function. EF – 60%. Normal chambers. Normal valves. Normal PA pressure. Normal LV diastolic function.

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

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94557 94557
1800 572 3003

Medway Group of Hospitals

Kodambakkam	Mogappair	Chengalpattu	Villupuram	Kumbakonam	Kakinada
044-2473 4455	044-26530011	044-27426829	04146-242000	044-2473 4455	0884-2333367

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

Medway Centre of Excellence (Chennai)

Heart Institute	Institute of Pulmonology
044 - 4310 8959	044-2473 4451

MHI/HOSP/2022/118



DAY CARE INITIAL ASSESSMENT FORM

Date: 8/1/24 Time of arrival: 11.18

Part A (to be filled by Nurses)

Vital Signs: Temp: 36.5 (°F) | Pulse / HR: 87 (beats/min) | BP: 125/83 (mmHg)

Respiration: 22 (breaths/min) | SpO₂: 99 (%) | Height: 170 (cms) | Weight: 95.3 (kgs) | BMI: 33 kg/m²

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

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

Psychosocial Assessment:

Alcohol Intake: ☐ Yes ☒ No

Substance Abuse: ☐ Yes ☒ No

Smoking: ☐ Yes ☒ No

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

If Yes, specify details: _____

Pain Screening

Pain: ☐ Yes ☒ No. If Yes, Score: 0/10

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

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

☒ Numerical Rating Scale (Age more than 12 years)

Duration: _____ Location: _____

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

Nutritional Screening:

Last 3 months Appetite ☐ Increased ☐ Decreased ☒ No Change

Last 3 months Weight ☐ Increased ☐ Decreased ☒ No Change

Fall Risk Screening for adults:

☒ No Risk

☐ Age more than 65 years

☐ History of fall in last 3 months

☐ Walks with assistance

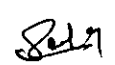
☐ Any neurological problem

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

Fall Risk Screening (for pediatrics)

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

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

	Signature	Name	Emp. No.	Date	Time
Nurse		<u>Michael Joseph E</u>	<u>802</u>	<u>8/1/24</u>	<u>11.20</u>

Chief Complaints

H/O chest pain twice on & off
no H/O breathlessness

HTW.

uncle bob

Significant Family History

[illegible]

Clinical Examination / Investigation

COY: 3-5-11
M: NUB 110.

also -

WBC: 18.

Crat: 1-00

HA: 142

~~Crat~~: 3-8-

Serology - negative

Provisional Diagnosis

HTA.

~~EDM~~

atypical chest pain

Plan of Care (including Investigations Ordered)

CAG:

Doctor's Signature

[Signature]

Name

Dr. Butler

Reg. No. 85851

Date 5/1/21

Time 11:50



DOCTOR'S PROGRESS NOTES

DATE	NOTES
	<u>com mts</u>
8/1/24 14:10	<p>Ap @ Radical cath</p> <p>2 minor cath</p> <p>per OMT</p> <p style="text-align: right;">com</p>
8/1/24 14:50	<p>ap @ B: Dr. G. Alihan.</p> <p>Cath from Cath lab</p> <p>Cath = Minor cath</p> <p>vitals stable -</p> <p>Plan:- OMT</p> <p style="text-align: right;">9/1/24</p>
8/1/24 18:30	<p>pt can be discharged today</p> <p style="text-align: right;">9/1/24</p>

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Mr. SRIRAM BABU

35/Male/MHI202481674

08/01/2024/UPH2024000063

Dr. G. GNANAVELU



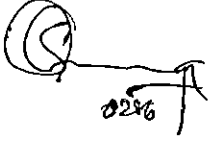
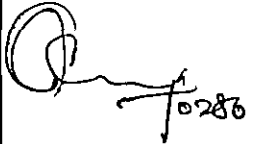
Diagnosis: <u>CAG / HTN / Diabetes / Neuropathy / EF-60% / Dyslipidemia</u>				
Height: <u>160</u> cms	Weight: <u>75.3</u> Kgs	Food allergies: Yes/No; If yes, specify.....		
Religious Beliefs:	<input type="checkbox"/> Vegetarian	<input checked="" type="checkbox"/> Non Vegetarian	<input type="checkbox"/> Eggetarian	<input type="checkbox"/> Jain
Diet Prescription: <u>1600 calories, low Fat, low salt diet</u>				

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

(A) Patient's related Medical History				
1) Weight Change (overall change in past 6 months)				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
No weight change/gain	<5%	5-10%	10-15%	>15%
2) Dietary Intake				
Oral	Sub-optimal solid diet	Full liquid diet/moderate overall decrease	Hypo-caloric liquid diet	Starvation
Enteral/Parenteral Nutrition	Sub-optimal	Inadequate	Hypo-caloric feeds	Starvation
3) Gastrointestinal Symptoms Duration:				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
No symptoms	Nausea	Vomiting/moderate GI symptoms	Diarrhoea	severe anorexia
4) Functional Capacity (Nutrition related functional impairment) Duration:				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
None/Improved	Difficulty with ambulation	Difficulty with normal activity	Light activity	Bed/chair-ridden with no or little activity
5) Co-morbidity (Disease and its relationship to nutrition requirements)				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Healthy	Mild co-morbidity	Moderate co-morbidity/age >75 years	severe co-morbidity	Very severe multiple co-morbidity
(B) Physical examination				
1) Decreased fat stores or loss of subcutaneous fat				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Normal	Mild	Moderate		Severe
2) Sign of muscle wasting				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Normal	Mild	Moderate		Severe
Total Score = Sum of above 7 components				
Nutritional Status : Based on this patient is				
Well Nourished		<input checked="" type="checkbox"/> (17 to 24)		
Moderately Malnourished		<input type="checkbox"/> (15 to 18)		
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:

(Signature) 20286 8/1/24, 12:00PM

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
<p>8/1/24 10:00</p>	<p>gentleman A 856 years old female came to c/o chest pain was assessed to be well-nourished as evident by SGA K/C/O - patient shifted to cath lab for procedure (UAG). kept on NBM. patient received to Radial lounge. kept on NBM. patient tolerated liquid diet. can tolerate a soft solid diet</p>	
<p>8/1/24 16:00</p>	<p>educated the patient & family on 1600 calories, low fat, low salt diet on discharge. Emphasized on small frequent meals. diet modifications & clarifications done. Diet chart given on discharge</p>	

PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: atrial flutter / AFN / ATYPICAL Allergies if any: N/A

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
ICU	Cath Lab	8/1/24	13:25	CAE

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

ASSESSMENT OF PATIENT:

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

Language Barrier: ☐ Yes ☒ No ☐ If Yes, specify: _____

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

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

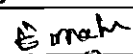

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
97.2	24	71	97%		0/10

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

Any pre-medication given: _____

Any critical information: _____

Any specific recommendation: _____

Handover by	Signature	Name	Emp. No.	Date	Time
		E. Mahalakshmi	202	8/1/24	13:25
Handed over to		Sandhya R	0004	8/1/24	13:25


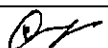
After Procedure:

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

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

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
97.8	22 br/min	93 beats/min	100%	151/93 (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)

Handover by	Signature	Name	Emp. No.	Date	Time
		Sandhya R	0004	8/1/24	14:30
Handed over to		S. Uma Subhaswari	0206	8/1/24	14:30

Mr. SRIRAM BABU

35/Malc/MHI202481674

08/01/2024/IPH2024000063

Dr. G. GNANAVELU



CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

CONDITION AND PROCEDURE

Dr. GNANAVELU has explained that I have the following condition:

Fat (cholesterol) and calcium can build up in the arteries like rust in old pipes. It can stop the flow of blood to the heart. This can cause angina or a heart attack. The Coronary Angiography procedure is performed to show up the amount of disease in the coronary arteries, the blood vessels that supply the heart with blood. After an injection of local anaesthetic, a fine tube (catheter) is put into the artery in the groin/hand. The tube is carefully passed into each coronary artery in turn. A series of video pictures are taken using x-rays and an iodine containing contrast medium (x-ray dye). The contrast medium may be injected into the main pumping chamber of the heart (left ventricle). This helps us to find out whether you have any narrowing or blockage of your coronary arteries. The doctor can then tell you which treatment is best for you after carefully studying and discussing your pictures. This may be an operation such as a coronary by-pass or a procedure called an angioplasty (the arteries are widened using a small sausage shaped balloon). Sometimes, drugs alone may be a suitable option.

RISKS OF THIS PROCEDURE

The risk of coronary angiography depends on:

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

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

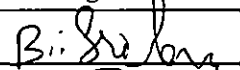
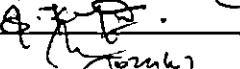
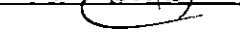
Less than 1 in 10,000 (0.0001%)	(a) skin injury from radiation, causing, reddening of the skin
1 in 1000 people (0.001%)	(b) A stroke. This can cause paralysis and long term disability (c) Heart attack. (d) A dangerous reaction to the x-ray contrast medium (dye). If this happens, you may have severe reactions such as asthma, shock and convulsions. Death in extremely rare cases about 1 in 2,50,000 to 4,00,000 injections. (e) Need for major surgery to the leg at the puncture site. (f) Need for emergency heart surgery or angioplasty. (g) A higher lifetime risk from x-ray exposure. (h) Death
1 in 100 people (0.01%)	(i) the heart may not beat in a proper rhythm which will need urgent treatment (j) Surgical repair of the groin puncture site. This may need a longer stay in hospital. (k) Minor reaction to contrast medium such as hives. (l) Loss/impairment of kidney function due to the contrast medium
1 in 20 people (0.05%)	(m) Major bruising or swelling at the groin puncture site
Most People	(n) Minor bruising

PATIENT CONSENT:

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

On the basis of the above statements,

I REQUEST TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship		SRIRAM	8/1/24	11.40
witness		KARUNYA (wife)	8/1/24	11.40
Doctor		Dr. G. Gnana Velu	8/1/24	11.40
Interpreter				

Patient Details (Affix Label here)

Name:

UHID:

DOB:

Sex:

இருதய ஆன்ஜியோகிராம் பரிசோதனைக்கான ஒப்பம்

நிலை மற்றும் செயல்முறை

பின்வரும் சூழ்நிலையை நான் கொண்டிருப்பதாக மருத்துவர் அவர்கள் விளக்கினார்.

பழைய இரும்புக் குழாய்களில் துருபிழிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாறடைப்பினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிறை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனாரி ஆஞ்சியோகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு ஹோக்கல் அனஸ்தீடிக் (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கத்தீட்டர்) கவட்டை/கையிலுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிறை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டுள்ள கான்ட்ராஸ்ட் மீடியத்தினை (எண்ஸ்ரே டைட்) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுபக்க இருதய கீழறை) இந்த கான்ட்ராஸ்ட் மீடியம் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்பு செய்கிறது என்பதை மதிப்பிடவும் மேற்கொள்ளப்படும். இப்பாடங்கள் நமக்கு இதயச்சுவர்சிறை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகிச்சையை மேற்கொள்ள முடியும். இவை பை-பாஸ் அறுவை சிகிச்சையாகவும் இருக்கலாம் அல்லது ஆன்ஜியோபிளாஸ்டி (புளூன் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

கிச்செயல்முறையிலுள்ள இடப்பாடுகள்

இதயச்சுவர் சிறை ஆன்ஜியோகிராஃபியிலுள்ள இடப்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிறை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள சில தீவிர இடப்பாடுகள் பின்வருமாறு. ஆனால் கிடைக்கக்கூடிய மட்டுமே முழுமையான இடப்பாடுகள் அல்ல

10,00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகிதம்)	(a) கதிர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
1000-ல் ஒருவருக்கு (0.001 சதவிகிதம்)	(b) வலிப்பு, இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாறடைப்பு (d) எக்ஸ்-ரே கான்ட்ராஸ்ட் மீடியத்தின் (டைட்) ஆபத்தான விளைவுகள். இவை ஏற்பட்டால் உங்களுக்கு ஆஸ்துமா, அதிர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2,50,000 முதல் 4,00,000 ஊசிகளில் ஒன்று மரணத்தையும் விளைவிக்கலாம். (e) குத்தப்பட்ட இடத்தில் பெரிய அறுவை சிகிச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரமாக இதய அறுவை சிகிச்சை அல்லது ஆன்ஜியோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதிர் பாதிப்பு காரணமாக அதிக வாழ்நாள் அச்சுறுத்தல் இடப்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(I) இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகிச்சை தேவைப்படும் (j) குத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகிச்சை சரிபாடு. இதனால் மருத்துவமனையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) கான்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலு குறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவினான சிராய்ப்பு அல்லது வீக்கம்
பெரும்பாலான மக்களுக்கு	(n) சிறிய அளவினான சிராய்ப்பு

நோயாளி ஒப்புதல்

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

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

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



JCI ACCREDITED



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PATIENT: Mr. ASHRAF M BABU

UHID: MHI202481674



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CORONARY ANGIOGRAM FINDINGS:Right-dominant system; **MINIMAL CORONARY ARTERY DISEASE.** (reports enclosed)**ADVICE :** Medical management.**ADVICE MEDICATIONS:**

Sl. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH FOOD	DURATION
			M	A	N			
1	TAB. CLOPILET	75 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. ROSUVAS	10 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. TELMA	40 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
4	TAB. RENERVE PLUS	1 TAB	0	1	0	ORAL	AFTER FOOD	TO CONTINUE

DISCHARGE ADVICE	
DIET	LOW FAT & SALT DIET.
PHYSICAL ACTIVITIES	AVOID STRENUOUS ACTIVITIES.
REVIEW	REVIEW WITH DR. G. SAMPATH KUMAR.

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

(for) 
Dr. G. SAMPATH KUMAR MD., DM., (cardio)
Consultant and senior interventional cardiologist

Typed by: Ezhilarasi. B. 

"I understood the Content of the
discharge summary."

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

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

Medway Centre of Excellence (Chennai)

Heart Institute | Institute of Pulmonology
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MHI/HOSP/2022/118



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TRANSRADIAL CORONARY ANGIOGRAM REPORT

Patient Name:	Mr.SRIRAM BABU	ID:	MHI202481674
Age/Gender :	35 M	IPH:	IPH2024000063
Cath No. :	3560	DOP:	08.01.2024
Done by	Assisted by	Technician	Physician assistant
Dr.G.R.Sampathkumar	Ms. Sathya	Mr. Pratap	Ms. Shalini

DIAGNOSIS: ATYPICAL CHEST PAIN;TMT +ve 7-2023; HBP; DYSLIPIDEMIA; NORMAL LV FUNCTION

Access: Right radial artery

Total exposure time: 1590"

Hardware used: 5F sheath, 5F TIG; JR/JL

Total DAP: 201.2 Gy.cm²

Contrast used: CONTRAPAQUE 60 ml

Total RAK: 344.1 mGy

Medications given: Inj NTG 200 mcg & Inj Heparin 2500 IU IA

Hemodynamic data: Aortic pressure: 136/90(103) mmHg; HR 105 bpm; SpO2 100%

Selective Coronary angiogram done in multiple angulated views:


Aberrant Right subclavian artery from descending aorta present

ARTERY	FINDINGS
LEFT MAIN	Normal. Bifurcates into LAD & LCx.
LAD	Type 2 vessel. Proximal LAD has luminal irregularities. Mid and Distal LAD appears normal. Gives two minor diagonals and many septals which appears normal.
LCx	Non Dominant. Proximal and Distal LCx appear normal. Gives 2 OMs, which appear normal.
RCA	Dominant. Proximal RCA appears normal. Mid and Distal RCA has luminal irregularities. Gives PDA and PLV which has luminal irregularities .

FINDINGS: RIGHT DOMINANT SYSTEM ; MINIMAL CORONARY ARTER DISEASE

ADVICE : MEDICAL MANAGEMENT


Dr. G.R.SAMPATH KUMAR, MD, DM


Dr. G. Gnanavelu (MD, DM (Radio), FACC
Chief Radiologist
19469

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

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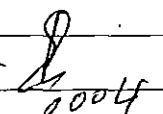
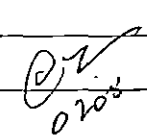
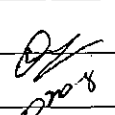
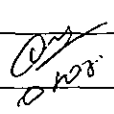

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MHI/HOSP/2022/118



DATE & TIME	Observation / Action	Signature with Emp.No			
	<u>Patient Admission notes</u>				
8/1/24 11:18	⇒ patient Received from RL conscious and oriented Patient vitals checked and recorded. NPO from 7:00AM IV line done today Patient Preparation done today	<u>[Signature]</u> 0004			
13:25	⇒ Patient up after complained ⇒ Patient Shifted to cath Lab	<u>[Signature]</u> 00			
	<u>CATH LAB REPORTS</u>				
8/1/24 13:30	⇒ patient received from RL to cathlab pt is conscious and good oriented. IV line patent v/p score 0/5.	<u>[Signature]</u> 0004			
13:35	⇒ Sterile drapping done.				
13:40	⇒ pt is continuously monitoring HR - 170 bpm BP - 141/86 mmHg SpO2 - 100%.				
13:50	⇒ CATH procedure start through right Radial artery approach under 4 local anes.	<u>[Signature]</u> 0004			
14:00	⇒ 45 NTU 200mls and 45 Heparin. 2500 units IAgiven. B/o Dr. Sampath Sir				
14:05	⇒ IVE all 40ml/hr outflow. B/o Dr. S. S. N				
14:25	⇒ procedure got over. pt is stable vitals are normal. HR - 105 bpm BP - 135/74, SpO2 - 100%.	<u>[Signature]</u> 0004			
Document endorsed by	Signature	Name	Emp. No.	Date	Time
	<u>[Signature]</u>	Sandhiya R	0004	08/1/24	14:25

DATE & TIME	Observation / Action	Signature with Emp.No
8/1/24 14:30	→ patient is continuously cardiac monitoring done. HR - Bp - SpO2 -	
14:30	→ patient shifted to RL with all documents → pt handing over to RL s/n.	 8004
14:30	Receiving notes pt received from AM lab to DE pt is conscious & oriented Spt vitals stable & pt had oral fluids right radial spiroset not going	 0208
15:00	→ pt voided	
15:15	→ pt had diet	
19:00	Discharge notes → pt iv line removed. → pt Discharge summary explained to the pt Attender. → pt old fl, new fl handed over to the pt Attender. → pt got discharged.	 0208  0208
Document endorsed by	Signature 	Name Mahabaleshwar
	Emp. No. 802	Date 8/1/24
	Time 19:00	

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

Mr. Sri Ram Babu
35 yrs / m
Dr. G. V.
IPH - 2024 000063

MHI/OT/2024/086

Name of the Procedure : CAT Location : CATH LAB - II Date & Time : 08/1/24
18:30

PATIENT LABEL

Does the Procedure involve Procedural Sedation : ☐ Yes ☒ No

SIGN IN <u>13:35</u> Before Induction of Procedural Sedation		TIME OUT <u>13:45</u> After procedural Sedation and before procedure		SIGN OUT <u>14:30</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	
Procedure	<input checked="" type="checkbox"/> Yes	Procedures	<input checked="" type="checkbox"/> Yes	Name and site of all specimens / investigations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	
Side	<input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	Side	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	confirms labeling and sent to lab	
Consent	<input checked="" type="checkbox"/> Yes	Position	<input checked="" type="checkbox"/> Yes	Any recovery concerns : <input checked="" type="checkbox"/> Yes <input type="checkbox"/> None	
Known Allergy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please specify	Consent	<input checked="" type="checkbox"/> Yes	If Yes, Pls. specify : <u>observation</u>	
Difficult airway / aspiration risk / dentures	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, equipment and assistance available	Required equipment and implants available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	Any Equipment / instrument problem that needs to be addressed : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Possibility of hypothermia	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, warmer in place	Essential Imaging displayed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	If Yes, Pls. specify :	
All concerned anesthesia equipment and medication check complete	<input checked="" type="checkbox"/> SpO2 <input checked="" type="checkbox"/> NIBP <input type="checkbox"/> Others pls. specify	Antibiotic prophylaxis within last 60 minutes	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	Corrective action :	
Pre OP medication taken	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Name of the Antibiotic given	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
Required equipment for procedure available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	Venous Thromboembolism Prophylaxis Provided	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Anticipated duration briefed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Anticipated blood loss briefed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Adequate fluids and blood available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Team briefed on any critical or unexpected steps	<input checked="" type="checkbox"/> Yes		
		For procedural sedation cases	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		Any patient specific concerns :	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		Intra procedure glycemic control	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		Any concerns about sterility	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure : <u>h</u>	Nurse : <u>RN. Sathy</u>	Technician : <u>ST. Sath</u>	Others Please Specify :	
Date : <u>08/1/24</u>	Date : <u>08/1/24</u>	Date : <u>08/1/24</u>	Date : <u>08/1/24</u>	Date :	
Time : <u>14:30</u>	Time : <u>14:30</u>	Time : <u>14:30</u>	Time : <u>14:30</u>	Time :	

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Procedure Monitoring Sheet (Cath Lab)

Patient Name : **Mr.SRIRAM BABU**
UHID / IP : 35/Male/MHI202481674
08/01/2024/IPH2024000063
Consultant : Dr.G. GNANA VELU

Age / Sex :

Ward Unit : RL

Diagnosis: Atypical / SHTM / Tm¹ / fu

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

PARAMETERS	YES	NO	NA
Vital signs : BP: 125/82 Temp: 97.2 Pulse: 90 RR: 20 SPO2: 97	✓		
Urine voided	✓		
Bowel preparation	✓		
Pre-procedure medication administered		✓	
Procedure site marked		✓	
Skin preparation done	✓		
NPO 7:00 PM	✓		
Loose Tooth removed			✓
Contact lenses / Eye glasses removed			✓
Prosthesis present		✓	
Jewellery/Nail polish removed		✓	
Checked for Allergies (Drug / food)		✓	
IV line/In-situ	✓		
Consent taken	✓		
Investigation reports / Documents received	✓		
Signature of Nurse : <i>[Signature]</i>	Date & Time : 8/1/24 @ 11:40		

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

Time	HR / min	RR / min	BP mmHg	SpO2%	Medication / Remarks	Sign. of Nurse
13:45	97 beats/min	20 br/min	147/86 (107)	100%	-	S2004
13:55	103 beats/min	24 br/min	150/95 (111)	100%	-	S2004
14:15	110 beats/min	24 br/min	142/93 (110)	100%	-	S2004
14:25	109 beats/min	24 br/min	137/93 (105)	100%	-	S2004
		procedure got over.				

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

Time: 14:30 Route: Right Radial artery approach

Complication: Nil

BP: 147/95 mmHg, HR: 91bpm, RR: 20b/min, SpO2: 100%

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

Advise:

- ◆ Shift To: Ward / ICU
- ◆ Bed rest up to 5-6 hours
- ◆ Observe puncture site for bleeding
- ◆ Watch for Pulse in Right Radial artery.
- ◆ Diet - Diabetic
- ◆ Inform Duty Medical Officer SOS
 - If patient complains of any Discomfort
 - If dressing is Loose or Socked with Blood
 - If limbs are Cold / Absent Pulse
- ◆ Remove The bandage dressing on 09/1/24 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
<u>08/1/24</u> <u>14:30</u>	<u>141/96</u>	<u>91</u>	<u>20</u>	<u>100%</u>	<u>Right Radial artery</u>	<u>no oozing</u>		<u>Poooy</u>

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

Condition at the end of procedure: ☒ Stable ☒ Critical

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

Name & Signature of the Nurse: Poooy
Sandhiya R


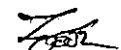






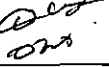

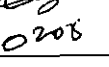
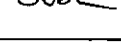
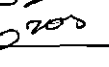
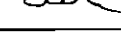
Date & Time: 08/1/24
2

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4		
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4		
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	4		
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4	4		
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation	4	4		
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3		
					TOTAL SCORE	28	28	
					Initial & Emp. No. of Staff Nurse:	[Signature] 08/01/24		
					Initial & Emp. No. of Sr. Staff Nurse:	[Signature] 08/01/24		

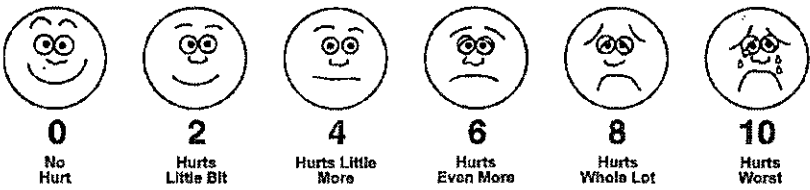
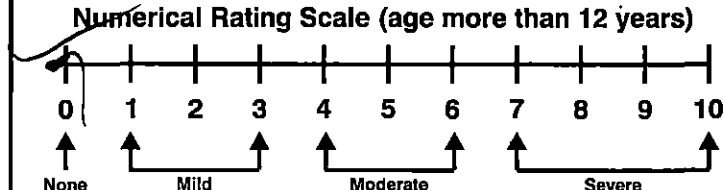
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6

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.
11/12/24 11:18	0/10	NO pain	-	-	-		
12:18	0/10	NO pain	-	-	-		
				pt received from left lab to RC			
14:30	0/10	No pain	-	-	-		
15:30	0/10	NO pain	-	-	-		
16:30	0/10	NO pain	-	-	-		
17:30	0/10	NO pain	-	-	-		
18:30	0/10	NO pain	-	-	-		
19:00	0	NO pain	pt go + Discharged				

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

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

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	8/1/24						
		Time	11.48						
S. No.	PARAMETERS								
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0							
2	Bedridden recently >3 days or major surgery within four weeks	0							
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0							
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0							
5	Entire leg swollen (Assess for both legs)	0							
6	Localized tenderness along the deep venous system (Assess for both legs)	0							
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0							
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0							
9	Previously documented DVT (Assess for both legs)	0							
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0							
FINAL SCORE		0							
Low Risk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8		Low							
DVT prophylaxis started		<input 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	<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

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



Mr. SRIRAM BABU

35/Male/MHI202481674

08/01/2024/IPH2024000063

Dr. G. GNANAVELU



MHI/NUR/2022/046



Where heart beat never stops...

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date									
	Time									
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		25	35							
Low Risk (0 - 24)										
Medium Risk (25 - 44)		✓	✓							
High Risk (45 or above)										
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

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

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