

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. MUNUSAMY

64/Male/MHI202481678

08/01/2024/IPH2024000062

Dr. G. GNANAVELU



MHI/IPD/2022/002



Every heart beat counts

ADMISSION SLIP

Admitting Doctor: Dr. Gnanavelu

Speciality: Cardiologist

Advised Date & Time: 8/1/24 @ 10:45 AM

Provisional Diagnosis: S. BTN / Acute ischaemic heart disease

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):

CAG

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: FST

Instructions to Nurse (if any):

Admission in PC

Any other Instructions (if any):

FST

Doctor's Signature

Dr. Gnanavelu

Name: G. Gnanavelu MD, DM (card) Reg. No.

Chief Cardiologist
Reg. No: 39469

39469

Date

8/1/24

Time

10:45 AM

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

8-1-24

11:12

8-1-24

11:12

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]

Raathiba K.I

0192

8-1-24

11:12

ADMISSION FORM

Marital Status M	Full Address 5/21 Perumal kovil street, Tyyapanthangal, Chennai - 56		Telephone Number 9094060420
Occupation RL			
Referred from Dr. G. G.	Date of Time of Admission 8-1-24 11:12	Date & Time of Discharge 8/1/24 @ 14:00	Total No. of Days 8 hrs.
UNIT RL	MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes AR No. : ---		
FINAL DIAGNOSIS			ICD Code
CAD - ILMZ - Lysed Stic (1/2024)			I25.1
ADEQUATE LV FUNCTION			I50.1
AORTA			I44.9
OLD PTB			A15.7
OLD CVA			I69.9
NEPHROPATHY			N17.4
SYSTEMIC HYPERTENSION			I10
DATE	OPERATION / PROCEDURES		ICPM Code
8/1/24	CORONARY ANGIOGRAM.		88.50
DATE	TYPE OF ANESTHESIA		
8/1/24	<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 Dr. G. G.		Signature of Medical Records Officer S. Alenkey	

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..... who is my (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 ஊழியர்கள் 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 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

8-1-24

எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of the Patient / Relative / Gurdian

உறவுமுறை

Nature of Relationship

மருமகன்

GENERAL CONSENT FOR ADMISSION


I, T. Munusamy 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		H. Munuswamy	8-1-24	11:12
Surrogate/Guardian (if applicable #)	S. Devi	S. Devi (Write name and relationship with patient)	8-1-24	11:12
Reason for surrogate consent	Patient is unable to give consent because:			
Witness	M. Nagalakshi	M. Nagalakshmi	8-1-24	11:12
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.	IPH2024000062	D.O.A	: 08/01/2024
UHID	MHI202481678	D.O.P	: 08/01/2024
Name	Mr. MUNUSAMY	Room No.	: RL
Age / Gender	64 Years /MALE		
Consultant	Dr. G. Gnanavelu. MD., DM., (cardio) FACC Chief Cardiologist	D.O.D	: 08/01/2024

DIAGNOSIS:

CAD- IWMI-LYSED STK (01/2024)

ADEQUATE LV FUNCTION

COPD

OLD PTB

OLD CVA

NEPHROPATHY

SYSTEMIC HYPERTENSION

PROCEDURE: CORONARY ANGIOGRAM DONE ON 08.01.2024 – SIGNIFICANT RCA DISEASE ; ANOMALOUS RCA ORIGIN.

BRIEF HISTORY:

Mr. Munusamy, 64years old male, presented with complaints of recent IWMI, treated outside conservatively, thrombolysis done and advised for Coronary angiogram and referred to Medway Heart Institute on 08.01.2024 for which he has been admitted.

ON EXAMINATION:

HR: 79bpm ; BP: 130/80mmHg ; SPO₂: 98% in room air

CVS: S1S2+ ; RS : Clear ; CNS: NFND; Abd: Soft

INVESTIGATIONS:

BLOOD: Hb- 12.6gm/dl, TWBC – 10150cells/cumm, PLT – 145000cells/cumm,

Urea – 27mg/dl, Creatinine – 1.31mg/dl, Sodium – 141mg/dl, Potassium – 4.94mg/dl, PT / INR – 12.0 /1.0.

ECG: sinus rhythm HR @ 83bpm, ST elevation in inferior leads, ST depression in I, aVL

ECHO: RWMA (+).Normal LV systolic function with reduced diastolic compliance. 1/4 MR No PE / clot.

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

f @MedwayHospitals

@medwayhospitals

in @medway-hospitals

@medwayhospitals



94557 94557
1800 572 3003

Medway Group of Hospitals

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

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
------------------------------------	---

MHI/HOSP/2022/118

CORONARY ANGIOGRAM FINDINGS:

Right-dominant system; **SIGNIFICANT RCA DISEASE / ANOMALOUS RCA ORIGIN.**(reports enclosed)

ADVICE : PTCA TO RCA.

ADVICE MEDICATIONS:

SL NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH FOOD	DURATION
			M	A	N			
1	TAB. ECOSPRIN	75 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. AX CER	90 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. NITROGLYCERIN	2.6 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB.TELMA	40 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
5	TAB.PAN	40 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
6.	TAB.ATORVAS	40 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
7.	TAB. FLAVEDON MR	35 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE

DISCHARGE ADVICE	
DIET	LOW FAT DIET.
PHYSICAL ACTIVITIES	AVOID STRENUOUS ACTIVITIES.
REVIEW	REVIEW WITH DR. G. GNANAVELU FOR PCI AFTER APPROVAL FROM ESIC HOSPITAL ON 12/1/2024.

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

S. Dena

Dr. G. Gnanavelu. MD., DM., (cardio) FACC
Chief Cardiologist

Typed by: Ezhilarasi.

Dr. G. Gnanavelu MD, DM (cardio), FACC
Chief Cardiologist
Reg. No: 39469

"I understood the Content of the discharge summary."

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

f @MedwayHospitals @medwayhospitals in @medway-hospitals @medwayhospitals

PATIENT HELPLINE
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

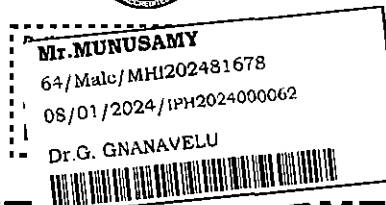
Medway Centre of Excellence (Chennai)

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

MHI/HOSP/2022/118



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



MHI/NUR/2022/203



Every heart beat counts

DAY CARE INITIAL ASSESSMENT FORM

Date: 8/1/24 Time of arrival: 11.30

Part A (to be filled by Nurses)

Vital Signs: Temp: 98 (°F) | Pulse / HR: 98 (beats/min) | BP: 130/80 (mmHg)
Respiration: 22 (breaths/min) | SpO₂: 98 (%) | Height: 166 (cms) | Weight: 65.6 (kgs) | BMI: 23.8 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		UMA MAHESWAR	6205	8/1/24	11-55

Part B (to be filled by Physicians)

Chief Complaints

Part B (to be filled by Physicians)

Chief Complaints H/O recent TIA, treated conservatively + thrombolysis done. Came for CAB.

Past Medical History

ECN
COPD.
Old PMB.
Old CVA.

Personal History

merged det..

Significant Family History

Current Medication

[illegible]

CB4-157mg/dl

Clinical Examination / Investigation

CUS: S5~@.

A-BARS@.

Echo
Adrenal gland.

MAI = 141.

W: 4.94.

urea: 27

Crab: 1.30

Serology - negative

Provisional Diagnosis

ACS / Jwmc-evolved.

HTN

COPD

Old PTB

Old CVA.

Plan of Care (including Investigations Ordered)

CALG

Doctor's Signature

[Signature]

Name

Dr. Pruthi

Reg. No.


25831

Date

8/1/20

Time

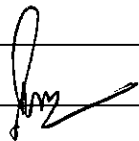
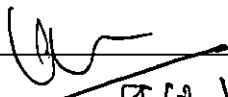
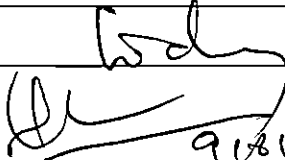
12.00



Mr. MUNUSAMY
 64/Male/MHI202481678
 08/01/2024/1PH2024000062
 Dr. G. GNANAVELU



DOCTOR'S PROGRESS NOTES

DATE	NOTES
8/1/24 1:35	<p><u>CAG</u></p> <ul style="list-style-type: none"> - Rt radial access - SF sheath - SF TICA → CAG done - Vasoactive Contrast <p><u>Imp:</u> Rt dominant / significant RCA disease / Anomalous RCA origin</p> <p><u>Adv:</u> PTCA to RCA.</p>
8/1/24 2:30pm	<p>40/13 = Dr. G. Anub - </p> <p>Can send for Cath lab</p> <p>CAG done -</p> <p>Vitals stable -</p> <p>plw = PCI to RCA.</p>
8/1/24 16:00pm	<p> 9/8/10 -</p> <p>pt can be discharged today</p> <p> 9/8/10</p>

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Diagnosis: CAG / ACS / HFN / COPD / OLD P/B / OTCVD

Height: 165 cms Weight: 65 Kgs Food allergies: Yes/ No; if yes, specify.....

Religious Beliefs: ☐ Vegetarian ☒ Non Vegetarian ☐ Eggetarian ☐ Jain


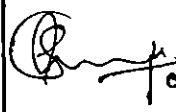
Diet Prescription: 1600 calories, low fat, low salt diet

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				
Duration: <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	Hypo-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 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"/> (7 to 14) <u>9</u>		
Moderately Malnourished		<input type="checkbox"/> (15 to 18)		
Severely Malnourished		<input type="checkbox"/> (19 to 35)		
Nutrition Interventions:				
<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		Fort - night <input type="checkbox"/> Monthly <input type="checkbox"/>		
Frequency of re-assessment: <input checked="" type="checkbox"/> Weekly <input type="checkbox"/> Daily		Calorie count: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

Dietitian Signature / Name / Date / Time:

G. Gnana Velu
8/1/24 12:00

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
<p>8/11/24. 12:00</p>	<p>A 64 years old gentleman came - c/o chest pain was assessed to be well-nourished as evident by SGA K/C/O - HTN. patient <u>shifted</u> to cathlab for procedure (CAG). kept on NBM. patient <u>received</u> Radial lounge. NBM over. patient tolerated liquid diet. can initiate soft solid diet.</p>	<p> 70286</p>
<p>8/11/24. 16:00</p>	<p>educated the patient & family on 1600 calories, low fat, low salt diet <u>on discharge</u>. Emphasized on small frequent meals. Diet modifications & clarifications done. <u>Diet chart</u> given on discharge</p>	<p> 70286</p>

PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: AKI, HTN, COPD Allergies if any: ANALGESIC

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
<u>ICU</u>	<u>Cath Lab</u>	<u>8/1/24</u>	<u>13:10</u>	<u>CORONARY ANGIOGRAM</u>

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
	<u>22</u>	<u>95b/min</u>	<u>98%</u>	<u>130/80</u>	<u>0/10</u>

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
	<u>[Signature]</u>	<u>SUMA MATHESWARAN</u>	<u>0208</u>	<u>8/1/24</u>	<u>13:15</u>
Handed over to	<u>[Signature]</u>	<u>V. Abinaya</u>	<u>0202</u>	<u>8/1/24</u>	<u>13:15</u>

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
<u>98.6</u>	<u>22 b/min</u>	<u>106 b/min</u>	<u>100%</u>	<u>155/76/105</u>	<u>1/10</u>

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
	<u>[Signature]</u>	<u>V. Abinaya</u>	<u>0202</u>	<u>8/1/24</u>	<u>14:45</u>
Handed over to	<u>[Signature]</u>	<u>R. Mohanmay</u>	<u>2362</u>	<u>8/1/24</u>	<u>14:45</u>

Mr. MUNUSAMY

64/Male/MHI202481678

08/01/2024/IPH2024000062

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:

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	<u>T. J. D. D. D. D.</u>	MR. MUNUSAMY	8/1/24	11.55
witness	<u>S. D. D. D.</u>	S. DEVI	8/1/24	11.55
Doctor	<u>Dr. G. Gnanavelu</u>	Dr. salad sudham	8/1/24	11.55
Interpreter				

Patient Details (Affix Label here)

Name:

UHID:

DOB:

Sex:

இருதய ஆன்ஜியோகிராம் பரிசோதனைக்கான ஒப்பம்

நிலை மற்றும் செயல்முறை

பின்வரும் கீழ்க்கண்டவையே நான் கொண்டிருப்பதாக மருத்துவர் அவர்கள் விளக்கினார்.

பழைய இரும்புக் குழாய்களில் துருபிழம்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாரடைப்பினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிரை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியோகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு லோக்கல் அனஸ்தீட்டிக் (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கத்திப்) கவட்டை/கையிலுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிரை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டிருக்கின்ற 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. இப்படங்கள் நமக்கு இதயச்சுவர்சிரை 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 ஆன்ஜியோபிளாஸ்டிக் (புரூன் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

இச்செயல்முறையிலுள்ள இடப்பாடுகள்

இதயச்சுவர் சிரை ஆன்ஜியோகிராஃபியிலுள்ள இடப்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

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

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) மாரடைப்பு (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) அவசரகால 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 செயல்படாமல் அல்லது அதன் வலு குறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவிலான சிராய்ப்பு அல்லது வீக்கம்
பெரும்பாலான மக்களுக்கு	(n) சிறிய அளவிலான 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 கொண்டள்ளேன். 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 கணிப்பீடுகள் 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 எனது சிகிச்சை விருப்பத்தேர்வுகள் குறித்த கவலைகளையும் என்னால் தெரிவிக்க முடிந்தது. என்னுடைய கேள்விகளும் மற்றும் கவலைகளும் கலந்தாலோசிக்கப்பட்டது மற்றும் எனக்கு திருப்திகரமான முறையில் அவற்றிற்கு பதிலளிக்கப்பட்டது. அசாதாரணமான கழுவில், எனக்கு இரத்தமேற்றுவதில், ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகிச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டுள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகிச்சையளிக்கப்படும் என்பதை எனக்கு விளக்கினார், இச்செயல்முறையினால் 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 NABH ACCREDITED

TRANSRADIAL CORONARY ANGIOGRAM REPORT*Every heart beat counts*

(A Unit of United Alliance Healthcare Pvt Ltd)

Patient Name:	Mr.MUNUSAMY	ID:	MHI202481678
Age/Gender :	64 M	IPH:	IPH2024000062
Cath-No. :	3561	DOP:	08.01.2024
Done by	Assisted by	Technician	
Dr.G.Gnanavelu/Dr.Karthik	Ms.Panchavarnam	Mr. Ram	

DIAGNOSIS: CAD; IWMI- LYSed STK(01/2024); HBP; COPD; OLD PTB; OLD CVA; NEPHROPATHY; ADEQUATE LV FUNCTION

Access:Right Radial artery

Total exposure time: 22'55"

Hardware used: 5F sheath, 5F TIG

DAP : 54.9 Gy.cm2

Contrast used: VISIPAQUE 50 ml

Total RAK: 440 mGy

Medications given: Inj NTG 100mcg + Inj Heparin 5000 IU IA

Hemodynamic data: Ao Pressure - 150/86(112) mmHg, HR - 67/min, Spo2 - 100%

Coronary angiogram done in multiple angulated views :

ARTERY	FINDINGS
LEFT MAIN	Normal. Bifurcates into LAD & LCx
LAD	Type 3 vessel. Proximal LAD has luminal irregularities. Mid LAD after major diagonal has 30-40% tubular stenosis. Distal LAD is normal. Gives one major diagonal and many septals which are normal.
LCx	Non Dominant. Proximal and Distal LCX are normal. Gives 3 OM's which are normal. OM2 is a major vessel.
RCA	Dominant. Anomalous RCA with posterior and downward facing origin in right sinus. Proximal RCA has 90% tubular stenosis. Mid RCA has luminal irregularities. Distal RCA is normal. PDA and PLv are normal.

FINDINGS: RIGHT DOMINANT SYSTEM; SIGNIFICANT RCA DISEASE; ANOMALOUS RCA ORIGIN**ADVICE: PTCA TO RCA**

Dr. G. GNANAVELU, MD, DM

Dr. G. Gnanavelu, MD, DM (cardio), FACC
 Chief Cardiologist
 Reg No: 39488

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

f @MedwayHospitals

@medwayhospitals

in @medway-hospitals

@medwayhospitals



94557 94557
 1800 572 3003

Medway Group of Hospitals

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

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
------------------------------------	---

MHI/HOSP/2022/118



DATE & TIME	Observation / Action	Signature with Emp.No
8/1/24 11-30	pt got admitted under Dr. Gnanavelu for angiogram NPO from 8 AM. Content taken. Skin preparation done. I.V line is patent.	 001
13-15	Shift the pt to cath lab on couch at.	 001
8/1/24 13-15	<u>CATH LAB</u> ⇒ pt received PC to cath lab ⇒ pt conscious & oriented pt vital stable pt is a fine patient	 001
13:45	⇒ sterile drapping done under the local anesthesia	 001
13:50	⇒ CAG procedure started Rt Radial artery approach.	 001
13:55	⇒ INJ: NTG 200 mcg + INJ: Heparin 2500 IU given (O/B DRUG/SIR)	 001
13:55	⇒ HR: 67 bpm BP: 154/86 (102) mmHg SpO2 100% vital stable.	 001
14:30	⇒ CAG procedure done Rt Radial artery sheath removed tight pressure bandage applied. no oozing no chamber.	 001
Document endorsed by	Signature 	Name Sathya
	Emp. No. 0016	Date 8/1/24
	Time 14:30	

[illegible]

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

MHI/OT/2022/086

Mr. MUNUSAMY

64/Male/MHI202481678

08/01/2024/IPH2024000062

Dr. G. GNANAVELU



Name of the Procedure : CAG Location : Cath Lab Date & Time : 8/1/24

Does the Procedure involve Procedural Sedation : ☐ Yes ☒ No

SIGN IN <u>13:40</u> Before Induction of Procedural Sedation		TIME OUT <u>13:45</u> After procedural Sedation and before procedure		SIGN OUT <u>14:35</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 type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> NA	confirms labeling and sent to lab	
Consent	<input type="checkbox"/> Yes	Position	<input checked="" type="checkbox"/> Yes	Any recovery concerns : <input type="checkbox"/> Yes <input checked="" 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
Possibility of hypothermia	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, warmer in place	Essential Imaging displayed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
All concerned anesthesia equipment and medication check complete	<input checked="" type="checkbox"/> SpO2 <input checked="" type="checkbox"/> NIBP <input checked="" type="checkbox"/> Others pls. specify <u>ECG</u>	Antibiotic prophylaxis within last 60 minutes	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
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	Any Equipment / instrument problem that needs to be addressed : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Required equipment for procedure available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	Venous Thromboembolism Prophylaxis Provided	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	If Yes, Pls. specify :	
		Anticipated duration briefed	<input checked="" type="checkbox"/> Yes		
		Anticipated blood loss briefed	<input checked="" type="checkbox"/> Yes <input checked="" 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 type="checkbox"/> Yes	Corrective action : <u>P</u>	
		For procedural sedation cases			
		Any patient specific concerns :	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
		Intra procedure glycermic control	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Any concerns about sterility	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		

Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure :	Nurse	Technician :	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>14:55</u>	Time : <u>14:55</u>	Time : <u>14:50</u>	Time : <u>14:50</u>	Time : <u>14:50</u>

Procedure Monitoring Sheet (Cath Lab)

Patient Name :

Mr. MUNUSAMY

Age / Sex : 64 / M

UHID / IP :

64 / Male / MHI202481678

Ward Unit : R

Consultant :

Dr. G. GNANA VELU

Diagnosis : ACS JUNE E

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

PARAMETERS	YES	NO	NA
Vital signs : BP: 140/90 Temp: 36.5 Pulse: 72 RR: 20 SPO2: 98%			
Urine voided	✓		
Bowel preparation			✓
Pre-procedure medication administered			✓
Procedure site marked			✓
Skin preparation done	✓		
NPO	✓		
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 @ 11.35		

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

Time	HR / min	RR / min	BP mmHg	SpO2%	Medication / Remarks	Sign. of Nurse
13:50	67/67/min	22/20/min	150/86 (112)	100%		<i>[Signature]</i>
14:05	67/67/min	20/15/min	154/92 (107)	100%		<i>[Signature]</i>
14:20	67/67/min	22/20/min	155/95 (105)	100%		<i>[Signature]</i>
procedure got over						

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

Time : 14:35 Route : Rt Radial artery approach
 Complication : Nil

BP : 155/76 (105) mmHg, HR : 68 bt/min, RR : 22 bt/min, SpO2 : 100%

Distal Pulse : felt, Puncture Site : no oozing no haematoma

Advise:

- ◆ Shift To: Ward / ICU
- ◆ Bed rest up to 4 hours
- ◆ Observe puncture site for bleeding
- ◆ Watch for Pulse in Rt Radial artery.
- ◆ 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 Radial dressing on 9/1/24 at 13:45 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 14:35	156/70	67	22	100%	no oozing no haematoma	Good	—	<i>[Signature]</i>

Nurses Notes :

CAG procedure done Rt Radial artery
 sheath removed tight pressure bandage applied.
 no oozing no haematoma catheter

Condition at the end of procedure : ☒ Stable ☐ Critical

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

Name & Signature of the Nurse

Date & Time :

[Signature]

8/1/24 14:45



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	3	3	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	3	3	
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	3	3	
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or 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	3	3	
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	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					13	13	
Initial & Emp. No. of Staff Nurse:					2	02	
Initial & Emp. No. of Sr. Staff Nurse:					8	8	

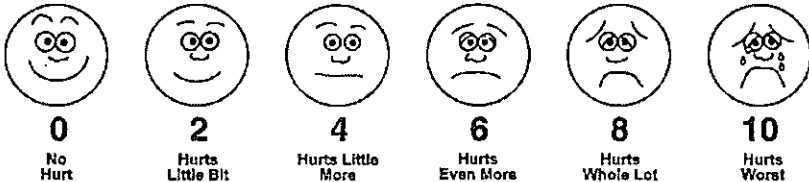
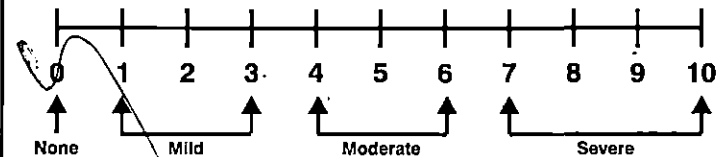
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6

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.
8/1/24 11:30	0/10	No pain	—	—	—	Dr. Suresh	Dr. Zoon
—	—	—	—	PT received from cath lab to OR	—	—	—
14:45	0/10	No pain	—	—	—	Dr. Suresh	Dr. Zoon
15:45	0/10	No pain	—	—	—	Dr. Suresh	Dr. Zoon
16:45	0/10	No pain	—	—	—	Dr. Suresh	Dr. Zoon
17:45	0/10	No pain	—	—	—	Dr. Suresh	Dr. Zoon
18:45	0/10	No pain	—	—	—	Dr. Suresh	Dr. Zoon
19:00	0/10	PT got 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)	 <div> <p>0 No Hurt</p> <p>2 Hurts Little Bit</p> <p>4 Hurts Little More</p> <p>6 Hurts Even More</p> <p>8 Hurts Whole Lot</p> <p>10 Hurts Worst</p> </div>					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						
		Time						
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		10						
Low Risk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8								
DVT prophylaxis started		<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	<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								

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	8/1/24	8/1/24							
	Time	11:30	11:45							
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		30	30							
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	✓	✓																	
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	✓	✓																	
Advise 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 (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)</																			

MEDWAY HOSPITALS

KODAMBAKKAM (HEART)

9, 1st Main Road, United India Colony , Kodambakkam, Chennai,

Tamilnadu, India

044-2473 4455

care@medwayhospitals.com

Registration No : MHI202481678

Patient Name : MUNUSAMY

Age : 64

Gender : Male

IP Number : MMH/HM/IPH2024000062

Discharge Date : 08/01/2024 5:22:00PM

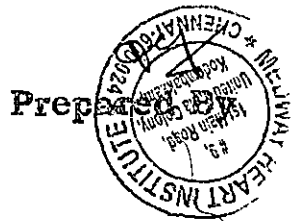
Bill No : MMH/HM/IPH202400055

Bill Date : 08/01/2024 5:20:40PM

Ward Name : RADIAL LOUNGE

Bed Name : V_RL-9

NO DUE



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. MUNUSAMY

64/Male/MHI202481678

12/01/2024/IPH2024000106

Dr. G. GNANAVELU



MHI/IPD/2022/002



Every heart beat counts

ADMISSION SLIP

Admitting Doctor: DR GNANAVELU

Specialty: Cardiology

Advised Date & Time: 12/1/24 11:28 AM

Provisional Diagnosis:

CAD - IWM (copd / old coA)

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):

PTCA

Blood Product Requirement:

☒ No

☐ Yes (Kindly specify details of components required in space below)

Expected Duration of Stay: 4 days.

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

Payer: ☐ Self ☐ Insurance ☒ Others:

ESI

ESI

Instructions to Nurse (if any):

monitored vitals
follow drug as per chart

Any other Instructions (if any):

Doctor's Signature

DR. GNANAVELU
Reg. No: 344884

Name

Dr. Gnanavelu

Reg. No.

39469

Date

12/1/24

Time

11:28

For admission desk staff only:

Room Category:

☒ General Ward

☐ Single Room

☒ Twin Sharing

☐ Deluxe Room

☐ Suite Room

☒ Others

Church 209

Admission intimation Receipt Details

Admission Time in HIS

Date

Time

Date

Time

12/1/24

12/1/24
11:28 PM

12/1/24

11:28 PM

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]

J. Leander

MA10273

12/4/24

11:28 PM

Medway Hospitals

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



Mr. MUNUSAMY

64/Mulc/MHI202481678

12/01/2024/IPH2024000106

Dr. G. GNANAVELU



MHI/HOSP/2022/129



ADMISSION FORM

Marital Status MARY	Full Address T. குதுமலி	Telephone Number 9094060419
Occupation	5/21 ஏபிமளர் கோவில் தெரு சென்னை - 56	
Referred from E.S.I	Date of Time of Admission 12/1/24 11:20 AM	Date & Time of Discharge 14/1/24
	Total No. of Days 3 days,	
UNIT card.	MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes AR No. :	
FINAL DIAGNOSIS		ICD Code
CAG - SIGNIFICANT RCA DISEASE; ANOMALOUS RCA		I25.10
ORIGIN (08.01.2024) CAD - I HMT - LVSED STK (01/2024)		I50.1
ADEQUATE LVEF/UNCTION. COPD, OLD PTB.		J44.9
OLD CVA - NEPHROPATHY SYSTEMIC HYPERTENSION		A15.0
		Z86.73
		I10
DATE	OPERATION / PROCEDURES	ICPM Code
12/1/24	SUCCESSFUL PTCA + STENT TO RCA DONE USING 3.5X24 MM ULTIMASTER DES DONE ON 12/1/24	00.66
DATE	TYPE OF ANESTHESIA	
12-11-2024	<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 Dr. G. GNANAVELU		Signature of Medical Records Officer [Signature]

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.....சு.வி.வி.வி. who is myசு.வி.வி.வி. (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 ஊழியர்கள் 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 மதிப்பிடக்கூடி பொருட்கள் யாவும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்ல
நெருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ளது. இந்த மருத்துவமனை எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை
என உறுதி செய்கிறேன்.

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

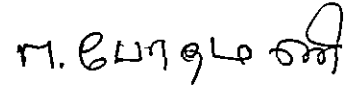


செவிலியர் கையொப்பம்

Signature of Admitting Nurse

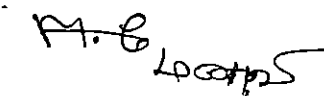
தேதி

Date 12/1/24



எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of the Patient / Relative / Guardian



உறவுமுறை

Nature of Relationship



Mr. MUNUSAMY
64/Male/MHI202481678
12/01/2024/IPH2024000106
Dr. G. GNANAVELU



GENERAL CONSENT FOR ADMISSION

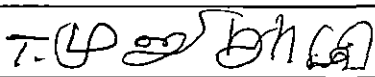
I, T. Gnanavelu the ☐ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ Read

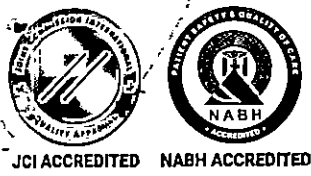
☐ Been explained this consent form in English, which I fully understand.

- 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		T. DEEPA	12/1/24	11:28 AM
Surrogate/Guardian (if applicable #)	M. EUNGOON	EUNGOON (Write name and relationship with patient)	12/1/24	11:28 AM
Reason for surrogate consent	Patient is unable to give consent because:			
Witness	S. DEVI	S. DEVI	12/1/24	11:28 AM
Interpreter (if applicable)				

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



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

DISCHARGE SUMMARY

IP No.	IPH2024000106	D.O.A	: 12/01/2024
UHID	MHI202481678	D.O.P	: 12/01/2024
Name	Mr. MUNUSAMY	Room No.	: 110
Age / Gender	64 Years /MALE		
Consultant	: Dr. G. Gnanavelu. MD., DM., (cardio) FACC Chief Cardiologist	D.O.D	: 14/01/2024

DIAGNOSIS:

CAG – SIGNIFICANT RCA DISEASE; ANOMALOUS RCA ORIGIN (08.01.2024)

CAD - IWMI - LYSED STK (01/2024)

ADEQUATE LV FUNCTION

COPD

OLD PTB

OLD CVA

NEPHROPATHY

SYSTEMIC HYPERTENSION

PROCEDURE:

SUCCESSFUL PTCA + STENT TO RCA DONE USING 3.5 X 24 MM ULTIMASTER DES DONE ON 12.01.2024.

BRIEF HISTORY:

Mr. Munusamy, 64years old male, presented with complaints of recent IWMI, treated outside conservatively, thrombolysis done and advised Coronary angiogram which revealed **SIGNIFICANT RCA DISEASE; ANOMALOUS RCA ORIGIN** on 08.01.2024 and further advised for PTCA to RCA. He came to Medway heart institute for PTCA for which he has been admitted.

No H/O fever, vomiting, diarrhea.

Known case of systemic hypertension on medication.

N/K/C/O Type II Diabetes mellitus, Dyslipidemia, and hypothyroidism.

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

PICCLE - NIL

HR - 70bpm

BP - 164/70 mmHg

SPO₂ - 97% in room air

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

f @MedwayHospitals @medwayhospitals in @medway-hospitals @medwayhospitals

PATIENT
HELPLINE
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



MUNUSAMY

UHID: MHI202481678



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

CVS - S1S2 (+)
RS - BAE (+)
Abdomen - Soft
CNS - NFND

INVESTIGATIONS :

BLOOD(09.01.2024): Urea – 24.88mg/dl, Creatinine – 1.33mg/dl, Sodium – 139mg/dl, Potassium – 4.60 mg/dl.

BLOOD: Hb- 12.6gm/dl, TWBC – 10150cells/cumm, PLT – 145000cells/cumm, Urea – 27mg/dl, Creatinine – 1.31mg/dl, Sodium – 141mg/dl, Potassium – 4.94mg/dl, PT / INR – 12.0 /1.0.

ECG: sinus rhythm HR @ 83bpm, ST elevation in II, III & aVF, ST depression in I, aVL

ECHO: RWMA (+) – mid inferior, mid posterior wall hypokinesia. Normal LV systolic function with reduced diastolic compliance. EF – 60%. 1/4 MR. No PE / clot.

POST PCI INVESTIGATIONS:

BLOOD(13.01.2024) :

Test Name	Result	Reference Value	Units
UREA	23	14 - 40	mg/dl
CREATININE	1.41	Male : 0.7 - 1.2 Female : 0.5 - 1.0 Child : 0.2 - 0.8	mg/dl

ECG : sinus rhythm, HR – 79 bpm, evolved IWMl changes.

SCREENING ECHO(13.01.2024) : S/P PTCA. Chambers normal sized. No RWMA. Normal LV systolic function. EF – 60%. Grade I diastolic dysfunction. Normal RV systolic function. Concentric LVH. Sigmoid septum. Aortic valve sclerosis. No AS/ AR. Trivial MR. Trivial TR. No PAH. No clot / vegetation / effusion.

COURSE IN THE HOSPITAL:

Mr. Munusamy, 64years old male, admitted with above mentioned complaints. Basic investigation was done. After obtaining consent, he underwent **SUCCESSFUL PTCA + STENT TO RCA DONE USING 3.5 X 24 MM ULTIMASTER DES DONE ON 12.01.2024** by Right radial artery approach. Post procedure was uneventful and shifted to CCU. Post procedure ECG shown no fresh ischemic changes. He was treated with dual anti-platelets, statin, nitrates, beta blockers and other supportive measures. His general condition improved. He got shifted to ward, RFT within normal limits, maintained adequate fluid balance. His medications are optimized and he is being discharged in a stable clinical condition.

CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile
General condition Stable

GCS - 15/15
Temp - 98.6°F
PR - 76/min
BP - 176/86mmHg
SPO2 - 98% in room air

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

f @MedwayHospitals @medwayhospitals in @medway-hospitals @medwayhospitals

PATIENT RELIEF
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



G. N. J. UNUSAMY

UHID: MHI202481678

IP.NO: IPH2024000106



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

ADVICE MEDICATIONS:

SI. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH MEAL	DURATION
			M	A	N			
1	TAB. ECOSPRIN (ASPIRIN)	75 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. AX CER (TICAGRELOR)	90 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
3	TAB.ATORVA (ATORVASTATIN)	40 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB.TELMA (TELMISARTAN)	40 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
5	TAB. FLAVEDON MR (TRIMETAZIDINE)	35 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
6.	TAB. NITROCONTIN (NITROGLYCERIN)	2.6 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
7.	TAB.PAN (PANTOPRAZOLE)	40 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
8	TAB. NIKORAN (NICORANDIL)	5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
9	TAB. NAC (N ACETYL CYSTEINE)	600 MG	1	0	1	ORAL	AFTER FOOD	X 1 WEEK
10.	NEB. LEVOLIN (LEVOSALBUTAMOL)	1 RESP.	1	1	1	P/N	AFTER FOOD	TO CONTINUE
11.	CAP. ABPHYLLINE (ACEBROPHYLLINE)	100 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE

DISCHARGE ADVICE

DIET	LOW FAT & SALT DIET.
PHYSICAL ACTIVITIES	AS TOLERATED & AVOID STRENUOUS ACTIVITIES
REVIEW	REVIEW WITH DR. GNANAVELU AFTER 1 WEEK WITH RFT & ECG REPORTS.

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."

S. Devi

Dr. G. Gnanavelu MD, DM (cardio), FACC
Chief Cardiologist
Reg. No: 39469

CONSULTANT SIGNATURE
Dr. G. Gnanavelu. MD., DM., (cardio) FACC
Chief Cardiologist

Typed by: Ezhilarasi.

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

f @MedwayHospitals @medwayhospitals in @medway-hospitals @medwayhospitals



94557 94557
1800 572 3003

Medway Group of Hospitals

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

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

MHI/HOSP/2022/118

INPATIENT INITIAL ASSESSMENT

Date: 12.1.24

Time of arrival in ward:

Allergies (if Yes, specify details):

Drugs ☐ Yes ☒ No

Blood Transfusion ☐ Yes ☒ No

Food ☐ Yes ☒ No

Others

Vital Signs: Temp: 98.6°F | Pulse / HR: 70 (beats/min) | BP: 164/70 (mmHg)

Respiration: 24 (breaths/min) | SpO₂: 97 (%) | Height: 165 (cms) | Weight: 70 (kgs) | BMI: 22.6 kg/m²

Pain: ☐ Yes ☒ No. If Yes, Score: 0/10

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

Duration: Location:

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

CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

A 64y/m came with H/O chest pain for day associated with vomiting & giddiness. H/O sweating. Then, he went nearby hospital & was diagnosed as AMI & he was thrombolysed by my STK on (01/2024). Then, he returned here & CAGI done on 08.1.24. now, he got admitted for further evaluation.

PAST MEDICAL HISTORY (with duration of illness):

Diabetes Mellitus: ☐ Yes ☒ No. If Yes, duration: Hypertension: ☒ Yes ☐ No. If Yes, duration: 1yr.

Others:

H/O treated for old PTB.

H/O treated for old CVA.

Past Surgical History:

H/O CAGI done on 08.1.24 showed significant RCA disease, Anomalous RCA origin

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. ECOSPRIN	75mg	P/o	0-1-0	11.1.24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2.	T. AX CER	90mg	P/o	1-0-1	"	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3.	T. NITROGLYCERIN	2 bmg	P/o	1-0-1	"	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4.	T. TELMA	40mg	P/o	1-0-0	"	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5.	T. PAN	40mg	P/o	1-0-0	"	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6.	T. ATORVAS	40mg	P/o	0-0-1	"	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7.	T. FLAUBEDON MR	35mg	P/o	1-0-1	"	<input checked="" 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

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:

S1 S2 ⊕

M2

Respiratory System:

BAE ⊕ no wheeze

Gastrointestinal System:

soft, non-tender - bcs - 15/15

Central Nervous System:

NFMND

Urinary / Reproductive / Locomotor System:

normal

Skin / Ophthalmic / ENT

normal

Suspected of contagious disease: ☐ Yes ☒ NoImmuno compromised status: ☐ Yes ☒ NoIsolation 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 ☒ NoReduced 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 - IWMF dysolstic / SHN / Adequate LV Function
Old PTB, old CHA

Plan of Care:

Admit ↓ to unanest

posted for PTCA today

NPO from 8am today

Consent

- parts preparation

- pre-medical

check pre - OPCS

Investigations Advised:

ECG, Sr. creatinine

Diet Advice:

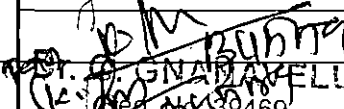
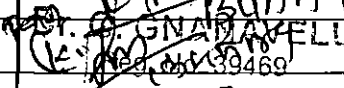
- ☐ Nil per Oral ☐ Clear liquid diet ☐ Normal liquid diet ☐ Diabetic liquid diet
☐ Semisolid diet ☐ Soft solid diet ☐ South Indian normal diet ☐ North Indian normal diet
☐ Neutropenic liquid diet ☐ Others: low salt, low fat

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		DR. Anusuya	184559	12/1/24	14.30
Consultant		Dr. Gnanavelu	39469	12/1/24	16.00
Patient Attendant	S. Dew	Relationship wife	—	12/1/24	14.30

CONSENT FORM FOR CRITICAL CARE (ICU)

I, Mrs. Dhanya 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.

☐ 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 reflatated 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): _____

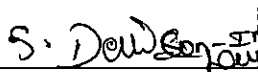
Possible alternatives:

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.

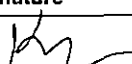
For the above-mentioned procedures that I have been made aware of, I give my consent voluntarily to doctor for carrying out the said procedure on myself or my above-named patient being fully aware of the nature, potential risks and complications, intended benefits and possible alternatives.

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 #)		S. Dawson - Son <small>(Write name and relationship with patient)</small>	12/1/24	17:10
Reason for surrogate consent	Patient is unable to give consent because:			
Witness				
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. Karthi	85855	12/1/24	17:10

உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

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

ட வாசித்திருக்கிறேன்

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

ட 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 முச்சுப் பெருங்குழலுக்குள் குழாய் செருகுதல் போன்ற அவசரநிலை மருத்துவ செயல்முறைகளை செய்யவும் இதன்வழியாக நான் ஒப்புதல் அளிக்கிறேன். மேலும் எனது நிலைமைக்கு சிகிச்சையளிக்க அல்லது அதனை மேம்படுத்த தேவைப்படும் கண்காணிப்பு வழிமுறைகளை மேற்கொள்ளவும் ஒப்புதல் அளிக்கிறேன்.

மைய சிரையில் 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; கடிந்து, 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, ஆண்டிபயாட்டிக் மருந்துகள் மற்றும் கீமோதெரபி போன்றவை இதற்கான மருந்துகளின் எடுத்துக்காட்டுகளாகும்.
- அதிக அளவிற்கு திரவம் அல்லது இரத்தத்தை அதிவேகமாக வழங்குவதற்கு; எடுத்துக்காட்டாக ஒரு நபர் அதிர்ச்சியில் ஆழ்ந்திருக்கும்போது.
- உயிருக்கு அபத்தான 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.
- பரிசோதனைகளுக்கு அடிக்கடி இந்த மாதிரிகளை அனுப்ப வேண்டிய தேவையுள்ள நோயாளிகளுக்கு திரும்பத்திரும்ப நோயாளிக்கு ஊசிக்குதி 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 பாக்கிரியா இரத்த ஓட்டத்திற்குள் கலப்பதற்கு இதனை எளிதானதாக ஆக்கிவிடும். கதிட்டர் பொருத்தப்படும் இடத்தை தூய்மைப்படுத்துவது 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 நிகழமானால், நுரையீரலிலிருந்து வெளியே கசிந்திருக்கின்ற காற்றை அகற்றுவதற்கு விவாதிக்க 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 இரத்தஓட்டத்தை.

சிகிச்சையின் மாற்று வழிமுறை விடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அணுகுவசதி

மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல்

மருத்துவ செயல்முறையின் சுருக்கமான விவரணை:

மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல் (Endotracheal Intubation) என்பது, தாங்களே சுயமாக சுவாசிக்க இயலாத அல்லது நினைவிழந்துவிட்ட நபர்களுக்கு செய்யப்படும் ஒரு அவசரநிலை சிகிச்சை செயல்முறையாகும். இது, ஒரு திறந்தநிலை மூச்சுப்பாதையை பராமரிக்க வகை செய்கிறது மற்றும் மூச்சுத்திறனால் நிகழாமல் தடுக்கிறது. நீங்கள் சுவாசிப்பதற்கு உதவு, உங்களது / உங்களது நோயாளியின் மூச்சுக்குழலுக்குள் ஒரு நெகிழ்வுத்திறன் கொண்ட பிளாஸ்டிக் குழாய் வாய் வழியாகப் பொருத்தப்படுகிறது. மூச்சுக்குழாய் என்றும் அழைக்கப்படுகின்ற இந்த மூச்சுக்குழல், ஆக்சிஜனை நுரையீரல்களுக்கு எடுத்துச்செல்லும் ஒரு குழாயாகும். சுவாசிப்பதற்கான இந்த குழாயின் அளவு நோயாளியின் வயது மற்றும் தொண்டை அளவிற்குப் பொருத்தமானதாக தேர்வு செய்யப்படும். உட்செலுத்தப்பட்டதற்குப் பிறகு குழாயை சுற்றி வீரிவைக்கின்ற காற்றின் ஒரு சிறிய சுற்றுப்பட்டையின் மூலம் உட்செலுத்தப்பட்ட குழாய் அதே இடத்தில் இருக்குமாறு வைக்கப்படும். மூச்சுக்குழாய், குரல்வலைக்கு சுற்றுகிற தொடங்குகிறது மற்றும் மார்பு ஊலப்பிற்கு பின்னே வரை அது நீள்கிறது. அதன்பிறகு மூச்சுக்குழாய் இரு சிறு குழல்களாக பிரிகிறது: வலது மற்றும் இடது பிரதான மூச்சு சிறுகுழாய்கள் ஒவ்வொரு சிறுகுழாயும், ஒவ்வொரு நுரையீரலோடு இணைக்கப்பட்டிருக்கிறது. இந்த மூச்சு சிறுகுழாய், அதன்பிறகு நுரையீரலுக்குள் சிறு சிறு காற்றுப் பாதைகளாக தொடர்ந்து பிரிகின்றன. மூச்சுக்குழாய் என்பது, கடினமான குருத்தெலும்பு, தசை மற்றும் இணைப்புத்தி ஆகியவற்றால் உருவானது. இதன் அகவுறை மிருதுவான திசுக்களால் ஆனது. ஒவ்வொரு முறையும் நீங்கள் / உங்களது நோயாளி காற்றை உள்ளே சுவாசிக்கும்போது மூச்சுக்குழாய் சற்றே நீளமானதாக மற்றும் விரிவானதாக ஆகிறது. மூச்சை வெளியே விடும்போது அதன் முந்தைய தளர்வான நிலைக்கு அது திரும்புகிறது. மூச்சுப்பாதையில் எந்தவொரு இடமும் சேதமடைந்திருக்குமானால் அல்லது தடை பட்டிருக்குமானால் உங்களால் சுவாசிக்க இயலாமல் போகலாம் அல்லது சுவாசிப்பதில் சிரமம் இருக்கலாம். இத்தகைய தடுணத்தில் தான் மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல் அவசியமாக இருக்கக்கூடும். இந்த செயல்முறை உங்களது மூச்சு / 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 மூச்சுப்பாதையை 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 மூச்சுக்குழாயில் காயம்
- இரத்தக்கசிவு
- நுரையீரல் சிக்கல்கள் அல்லது காயம்
- உறிஞ்சி வெளியிழுத்தல் (வயிற்றிலுள்ள உணவுப்பொருட்களும், அமிலங்களும் நுரையீரல்களில் சேர்ந்திருக்கும்போது)
- பிற இடர்கள் (ஏதும் இருக்குமானால்):

சாத்தியமுள்ள மாற்று வழிமுறைகள்:

உடலுக்குள் ஊடுருவாத சுவாச ஏதாவாக்கல் முறையானது, சில சூழ்நிலைகளில் உதவிகரமாக இருக்கக்கூடும். ஆனால், மூச்சுப் 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 உறுதிபட தெரிவித்துக்கொள்கிறேன். பெரும்பான்மையான நோயாளிகளுக்கு அசம்பாவிதம் இல்லாமல் அறுவைசிகிச்சை மற்றும் மீண்டு குணமடைதல் நிகழ்கின்ற நேரவில், சில நேரங்களில் 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 மனநலம் கொண்ட நபராக இருக்கிறேன் மற்றும் எந்தவித அச்சம், அச்சுறுத்தல் அல்லது தவறான கண்ணோட்டம் இல்லாமல் இச்செயல்முறைக்கு ஒப்புதல் அளிக்கிறேன் என்று இதன் மூலம் நான் மேலும் உறுதிமொழியளிக்கிறேன்.

நோயாளி	கையொப்பம் / கட்டைவிரல் ரேகை*	பெயர்	தேதி	நேரம்
பதிலாளி / பாதுகாவலர் (பொருத்தமானால் *)		(பெயர் & நோயாளிக்கு என்ன உறவுமுறை என்பதை எழுதவும்)		
பதிலாளி 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 ஆவணத்தில் விவரிக்கப்பட்டபடி, தகவலை முழுமையாக புரிந்துகொண்டுள்ளார் என்பதை நான் உறுதியாக நம்புகிறேன்.

மருத்துவர்	கையொப்பம்	பெயர்	பதிவு எண்.	தேதி	நேரம்

DOCTOR'S PROGRESS NOTES

DATE	NOTES
12/1/24	
16.00	<p>(R) Radial PCT to RRA RRA cannulated & 6F Sheath inserted RCA engaged & 1st MP GC + RRA moved & 0.014 BILW & pulled - POA Lesion predilated & 2x10 SC @ 10 atm. for 10 sec Lesion dilated & 3.5x24 DBS, Ultimaster @ 12 atm for 20 sec stlhd Lesion post dilated & 4x24 WC @ 14 atm for 10 sec. from distal to proximal.</p>
	<p><u>Re</u> As per chd (2) T. Nikoran 5mg PO (3) WP NS 3ml/hr</p>
	<p><i>[Signature]</i> 9/3/24</p>
12/1/24	<p>9/3/13: Dr. G. Gnana Velu</p>
5:45	<p>com Pump from Lath lab. x/p PCT to RCA done today. HA = 78/120, BP = 110/70 SpO₂ = 95% - SAT -</p>

TERUMO
Ultimaster™
3.5-24
DE-RD3524KSM
LOT 230509



Medway Hospitals®

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



P: Mr. MUNUSAMY
M: 64/Malc/MHI202481678
U: 12/01/2024/IPH2024000106
D: Dr. G. GNANAVELU
C:

MHI/ICU/2022/040



Every heart beat counts

Date: 12/1/24

Time: 8:30 PM

Doctor's Name: Dr. Velumyan P.

ICU PROGRESS NOTES

ICU SCORES
(as Appropriate)

CLIF ACLF / AD score:
SOFA score:

MELD score:
SAPS II score:

AARC score:
APACHE II score:

ICU Day - 1
Background

90 CAD - AG

Issues last 24 hours

PCI to RCA

Central nervous system

Conscious / oriented / sedated with

Sedation score

GCS - E₄ V₄ M₆

Pain score

Pupils - L₄ M₄

Drains

Cardiovascular system

HR - 74/min Rhythm ~~NSR~~ Cardiac Output -

BP - 120/80 CVP -

Cardiac Medications:

Respiratory system

Oxygen supplementation - ~~NC~~

Saturation / PaO₂ -

Ventilator: Spontaneous / Controlled



Last C x R -

Drains -

on line

GIT

P/A ~~AT~~

Bowels - ~~Y/N~~ Loose stools / Melena

Drains

NG tube: ~~Y/N~~

Day NGA -

USG

CT

Nutrition & Fluids

Oral feeds / NG feeds

TPN - formula used

Supplements

Calories / Proteins achieved:

IV fluids -

24 hour Urine output

Fluid balance

Creatinine clearance

Acidosis

Lactate

RRT - SLED / IHD / CRRT

Adequate

Microbiology

Invasive lines

1. ~~over~~

2.

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

1.

2.

3.

Labs

Hb ~~Ana~~ TC

Platelets

Urea Creatinine

Na K

Bilirubin AST ALT

INR

Others

DVT prophylaxis - ~~Y/N~~

Drugs: Mechanical - TEDS / SCD

Stress Ulcer Prophylaxis - ~~Y/N~~

Drugs

Pressure sore Y / N

Alpha bed Y / N

Date : 13/1/24

Time : 8:00

ICU PROGRESS NOTES

Doctor's Name : Dr. Kuttar

ICU SCORES
(as Appropriate)

CLIF ACLF / AD score:
SOFA score:

MELD score:
SAPS II score:

AARC score:
APACHE II score:

ICU Day
Background

ACS-CAD
Juni.
PCI-PTA

Issues last 24 hours

Central nervous system

Conscious / oriented / sedated with

Sedation score

GCS - E V M

Pain score

Pupils

Drains

Cardiovascular system

HR - 87 Rhythm - Sin. Cardiac Output -

BP - 150/90 CVP -

Cardiac Medications:

Respiratory system

Oxygen supplementation -

Saturation / PaO2-

Ventilator : Spontaneous / Controlled



Last C x R -
Drains -

GIT

P/A

Bowels - Y / N Loose stools / Melena

Drains

NG tube : Y / N

Day

NGA-

USG

CT

Nutrition & Fluids

Oral feeds / NG feeds

TPN - formula used

Supplements

Calories / Proteins achieved :

IV fluids -

24 hour Urine output

Fluid balance

Creatinine clearance

Acidosis

Lactate

RRT - SLED / IHD / CRRT

Microbiology

Invasive lines

1.

2.

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

1.

2.

3.

Labs

Hb

TC

Platelets

Urea 23

Creatinine 1.4

Na

K

Bilirubin

AST

ALT

INR

Others

DVT prophylaxis

Drugs :

Mechanical - TEDS / SCD

Stress Ulcer Prophylaxis

Drugs

Pressure sore


Alpha bed

Plan for the day

After

Dys as checked
Ho chb
ment or wry
probs e
Gral feeds.
2nd LAs 5-5

Pr

Doctor	Signature	Name	Reg. No.	Date	Time
		Dr. [Name]	85957	10/1/24	



64/Malc/MH1202481678
12/01/2024/IPH2024000106

Dr.G. GNANAVELU

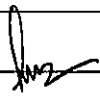


MHI/IP/2022/041



Every heart beat counts

DOCTOR'S PRELIMINARY NOTES

DATE	NOTES
13/1/24 9 AM	S/B Dr. Gnanaseelan & team - Pt reviewed. No fresh complaints
C&G - 114 T 900 Q 2100	O/E = Gnanaseelan, oriented - afebrile PR - 76/min, BP - 135/96 (109) SpO ₂ 99% RA Aus = S ₁ S ₂ ⊕ RL = BAE ⊕
ECG - Sinus rhythm - LAD - Prolonged QTc - No fresh changes	Ado - Dig. Desophtylin 200 IV - Neb DuoLyn 1-1 - Orem cont the same - Shift to room after
	Screening ECHO.
	 97211

DATE

NOTES

13/1/29S/B Dr. Mohamed Hydros

10pm.

A: ACS-CAD / IWM I / PCI-
PCA

Patient status

oriented

afebrile

vitals

PR-62/min

RR-18/min

BP-130/80mmHg

SpO₂ 97%

CVS → S1S2 ⊕

RS → BAC ⊕

P/A → soft, NT


Adv

- monitor vitals

- PO follow

drug chart

- PO norm D/c


Korany



MR. MUNUSAMY

64/Malc/MH1202481678

12/01/2024/IPH2024000106

Dr.G. GNANAVELU



1'2022/041

Medway
earth
titute

Heat counts

DOCTOR'S PROGRESS NOTES

[illegible]

Every heart ~~beats~~ counts

Mr. MUNUSAMY

64/Male/MHI202481678

64/Male/MH120212
12/01/2024/IPH2024000106

Dr.G. GNANAVELU



DIABETIC CHART

ACTUAL WEIGHT 70 kg HbA_{1c} 5.9

PREVIOUS DIABETIC MEDICATIONS

[illegible]

INSTRUCTIONS FOR INSULIN INFUSIONS

	BLOOD SUGAR mg / dl	INSULIN INFUSION
* Mix 40u short acting Insulin in 40 ml. of normal Saline (IU - 1 ml.)		
* Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).	< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
* Monitor Blood Glucose hourly (every 2nd hourly when stable) and adjust Insulin rate according to the following Algorithm.	150-200	Adjust Infusion rate to 2u / hr.
	201-250	Adjust Infusion rate to 4u / hr.
	251-300	Adjust Infusion rate to 6u / hr.
* Target Blood Sugar 150-200 mgs.	301-350	Adjust Infusion rate to 8u / hr.
	351-400	Adjust Infusion rate to 10u / hr.
* To monitor K+ separately.	>400	Adjust Infusion rate to 20u / hr.
Urine Acetone <input type="text"/>		

BLOOD GROUP

"B" positive

INVESTIGATION SHEET

Mr. MUNUSAMY

64/Male/MHI202481678

12/01/2024/IPH2024000106

Dr.G. GNANAVELU



Date	12/1/24	13/12/24				
HAEMATOLOGY						
Hb	126.					
P.C.V						
Platelets						
TLC						
Polymorphs						
Lymphocytes						
Eosinophils						
Mono / Basophils						
E.S.R						
BIO-CHEMISTRY						
Urea		23				
Creatinine	1.35	1.41				
Sodium						
Potassium						
Bicarbonate						
Chloride						
Magnesium						
Calcium						
Phosphorus						
LFT						
T.Bilirubin						
D.Bilirubin						
I.Bilirubin						
S.G.O.T						
S.G.P.T						
ALP						
GGT						
Total Protein						
S.Albumin						
CARDIAC ENZYMES						
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						



BLOOD GROUP "B" POSITIVE	
ON ADMISSION	
Height in CM	Weight in Kg.
165cm	70kg

Procedure: PTCA to RCA

NO. OF DAYS																																																												
DATE																																																												
HOUR																																																												
40.5°																																																												
40°																																																												
39.5°																																																												
39°																																																												
38.5°																																																												
38°																																																												
37.5°																																																												
37°																																																												
36.5°																																																												
36°																																																												
PULSE																																																												
RESP																																																												
B.P.																																																												
SPO2																																																												
DAILY WEIGHT																																																												
24 HRS INTAKE																																																												
24HRS OUTPUT																																																												
BALANCE																																																												
MOTION																																																												

EARLY MONITORING CHART

Name:

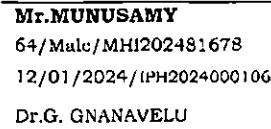
Age/Sex:

Patient Id No:

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

Note: Nurses are trained 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 nd Hourly
	2	Every 4 th Hourly



Medway Heart Institute
Every heart beat counts

[illegible]



Dr.G. GNANAVELU



Medway
Heart
Institute

Every heart beat counts

Date	From:	To:	Bed No:												
13/09/24	10:14	01/24	204 A												
24 Hrs : Started Time :		Ended Time :													
NPO Started at :		NPO Over at :													
SHIFT	Morning	Afternoon	Night												
INTAKE	200	300	750 ml.												
OUTPUT	400	600	650 ml.												
Total Intake:	1250 ml	Total Output:	1700 ml												
		Difference: 450 ml													
INTAKE (ml)				OUTPUT (ml)											
Time	Oral	Tube Feeding	Intravenous Infusion			Total	Time	Urine	Vomit	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
			Type of Fluid	Additions	Amount										
				Patient received from CCU bath tub.											
07-120	200					200	13/11/24	@ 14.00							
12-10	150					350	9-00	400					400		
18-00	150					500	12-00	250					650		
20-30	150					650	16-00	250					900		
22-30	200					850	18-30	150					1050		
4-50	200					1050	20-30	150					1200		
6-30	200					1250	2-30	200					1400		
							6-30	300					1700		
TOTAL INTAKE - 1250 ml															
TOTAL OUTPUT - 1700 ml															
BALANCE - 450 ml															



Date		From: 14/01/24		Bed No: 204		INTAKE & OUTPUT CHART									
24 Hrs : Started Time : 7-00		Ended Time : 7-00													
NPO Started at :				NPO Over at :											
SHIFT	Morning			Afternoon			Night			Restricted Fluid (RF)					
INTAKE	350 ml														
OUTPUT	500 ml														
Total Intake:				Total Output:				Difference:							
INTAKE (ml)							OUTPUT (ml)								
Time	Oral	Tube Feeding	Intravenous Infusion			Time	Urine	Vomit	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by	
			Type of Fluid	Additions	Amount										
7.30	100					7-00	250					250			
8.30	100					8-30	150					400			
11.30	150					11-00	100					500			
discharged															

PRE/POST OPERATIVE ECHO

Mr. MUNUSAMY

64/Male/MHI202481678

12/01/2024/IPH2024000106

Dr.G. GNANAVELU



Screening Echo

Date & Time	SIP PTA.	
13/01/2023	<ul style="list-style-type: none"> Chambers normal sized. No RWMA Normal LV systolic function Grade I diastolic dysfunction Normal RV systolic function Concentric WH Sigmoid septum Aortic valve sclerosis No AS/AR Trivial MR. Trivial TR. NO PAH No clot/vegetation/fusion. 	
	LVDD: 46 mm	E/A: 0.66
	LVDS: 31 mm	Med E/E': 11.20
	EF: 60%	Lat E/E': 6.25
		TRPG: 10 mmHg
	EDVI 64ml	RVSP: 20 mmHg
	ESV: 28ml	TAPSE: 18mm
	EF: 55%	
	Done by: Libiah (PA, RES)	
	MHI/0053/AN	

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

Mr. MUNUSAMY

64 / Male / MHI202481678

12/01/2024 / IPH2024000106

Dr. G. GNANAVELU



Diagnosis: CAD - IHD / PCHA / HbA1c - 5.9 (Pre-diabetic) / HT - 60 / COPD / Old PTB /

Height: 165 cms Weight: 70 Kgs Food allergies: Yes/ No, if yes, specify: Old CWA / HTN / No allergy.

Religious Beliefs: ☐ Vegetarian ☒ Non Vegetarian ☐ Eggetarian ☐ Jain

Diet Prescription: 1600 calories, low fat, low salt, diabetic diet.




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				
Duration:	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
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	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"/> (7 to 14)		
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 counts: <input type="checkbox"/> Yes		<input checked="" type="checkbox"/> No

Dietitian Signature / Name / Date / Time:

Maria Catherine John
Senior Dietitian

12/1/24, 18:00

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
12/1/24, 18:00	<p>A 64 year old gentleman came to do chest pain x-ray (1 day) was assessed to be well nourished as evident by SGA.</p> <p>Hx - CAD / COPD / WDM / old PTD / old CVA.</p> <p>Patient <u>shifted</u> to <u>bedside</u> for procedure (PCA) and kept on PCA. Patient <u>void</u> to ur. 10:00 am. Patient <u>denied</u> diabetes; liquid diet. Can <u>initiate</u> on diabetes; soft solid diet.</p>	 Maria Catherine John Senior Dietitian
12/1/24, 11:00	<p>Patient <u>void</u> to ward. Reemphasized on the diet instruction. Nourished to eat well.</p>	 Maria Catherine John Senior Dietitian
12/1/24, 10:00	<p>Diet intake is good. Educated the patient and family on 100 calories, low fat, low salt, diabetes diet on <u>discharge</u>.</p> <p>Emphasized on small fruit meals & low glucose control. Diet modification and clarification done. Diet chart given on discharge.</p>	 Maria Catherine John Senior Dietitian

PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: CAD - ILMI

Allergies if any: NKDA

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
<u>2nd Floor Cath Lab</u>	<u>Cath Lab</u>	<u>12/1/24</u>	<u>14.50</u>	<u>PTCA</u>

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
<u>97.1</u>	<u>24</u>	<u>70</u>	<u>97</u>	<u>180/70</u>	<u>-</u>

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: _____

	Signature	Name	Emp. No.	Date	Time
Handover by	<u>[Signature]</u>	<u>R. Sushma</u>	<u>0201</u>	<u>12/1/24</u>	<u>14.50</u>
Handed over to	<u>[Signature]</u>	<u>Navathani</u>	<u>0186</u>	<u>12/1/24</u>	<u>14.50</u>

After Procedure:

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

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

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
<u>98.0</u>	<u>22</u>	<u>70</u>	<u>100</u>	<u>168/88 (102)</u>	<u>0/10</u>

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	<u>[Signature]</u>	<u>Navathani</u>	<u>0186</u>	<u>12/1/24</u>	<u>17.25</u>
Handed over to	<u>[Signature]</u>	<u>R. Mohanraj</u>	<u>2352</u>	<u>12/1/24</u>	<u>17.30</u>

Mr. MUNUSAMY 64/Male/MHI202481678 12/01/2024/IPH2024000106	ADIOGRAM / CORONARY ANGIOPLASTY
Patient Name Dr. G. GNANAVELU	Sex: M/F
Consultant:	UHID

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: Gnanavelu

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 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	T. D. Gnanavelu	T. D. Gnanavelu	12/1/24	12.30
witness	S. Devi	S. DEVI	12/1/24	12.30
Doctor	Dr. Karthik	Dr. KARTHIK	12/1/24	12.30
Interpreter				

நோயாளியின் பெயர்:	வயது:	பாலினம்: ஆண் / பெண்
மருத்துவ ஆலோசகர்:	வார்டு படுக்கை எண்:	யுஹெச்ஐடி (UHID) :

நிலை மற்றும் செயல்முறை

பின்வரும் சூழ்நிலையை நான் கொண்டிருப்பதாக மருத்துவர் அவர்கள் விளக்கினார்.

பழைய இரும்புக் குழாய்களில் துருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாரடைப்பினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிறை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியோகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு லோக்கல் அனஸ்தீடிக் (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கத்தீடர்) கவட்டை/கையினுள்ள 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. இப்படங்கள் 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 ஆன்ஜியோபிளாஸ்டிக் (புலான் வழுவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

இச்செயல்முறையிலுள்ள இடர்பாடுகள்

இதயச்சுவர் சிறை ஆன்ஜியோகிராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

- (i) இதயச்சுவர் சிறை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள சில தீவிர இடர்பாடுகள் பின்வருமாறு. ஆனால் கிடைக்கக்கூடிய மட்டுமே முழுமையான இடர்பாடுகள் 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) மாரடைப்பு (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) அவசரகால இதய அறுவை சிகிச்சை அல்லது ஆன்ஜியோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதிர் பாதிப்பு காரணமாக அதிக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(I) இதயம் சரியான முறையில் துடிக்கலாம் 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 அளவினை சிராய்ப்பு அல்லது வீக்கம்
வரும்பாலான மக்களுக்கு	(n) சிறிய அளவினை சிராய்ப்பு

நோயாளி ஒப்புதல்

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

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

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



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

TRANSRADIAL PERCUTANEOUS CORONARY INTERVENTION REPORT

Patient name	MR. MUNUSAMY	ID	MHI202481678
Age/Gender	64 M	IP No.	IPH2024000106
Cath No.	3603	D.O.P.	12.01.2024

Done by Dr. KARTHICK; Dr.G.GNANAVELU

Technician : Mr. Ram

Scrub nurse : Ms. Sathya

DIAGNOSIS : CAD – IWMI-LYSED STK (01/2024); SHTN; COPD; OLD PTB; OLD CVA
NEPHROPATHY; ADEQUATE LV FUNCTION.

CAG: SIGNIFICANT DISEASE OF MID RCA (ANOMALOUS ORIGIN)

APPROACH : Right radial artery

EXPOSURE TIME: 1095 sec

HARDWARE : 6F hemostatic sheath, 6 F MP 1.0 guide

RAK: 271 mGy

CONTRAST : OMNIPAQUE 200 ml

DAP : 77 Gy.cm2

MEDICATIONS: Inj NTG 200 mcg IA; Inj. Heparin 8500 IU IA;

HEMODYNAMIC DATA: ABP 104/70 (81) PULSE 91 bpm SPO2 100%

ARTERY	LESION	GUIDE WIRE	PRE DILATATION	STENT	POST DILATATION	RESULT
MID RCA	90% tubular stenosis	BMW	2 x 10 SC Balloon 10 atms	ULTIMASTER 3.5 x 24mm 11 atms 20 s	3.5 X 8 NC balloon 14 atms	TIMI III FLOW

REMARKS: Uneventful procedure. Inj Nikorandil 2mg given intracoronary after postdilatation.
ACT at the end of the procedure was 259 s.

RESULT: SUCCESSFUL PTCA X LAD


Dr. G. GNANA VELU, MD, DM

Dr. G. Gnana Velu MD, DM (cardio), FACC
Advisor & Mentor
Chief Cardiologist
Reg. No: 39469

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

f @MedwayHospitals

@ @medwayhospitals

in @medway-hospitals

@ @medwayhospitals



94557 94557
1800 572 3003

Medway Group of Hospitals

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

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
---	--

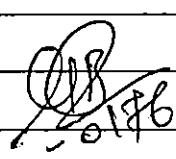
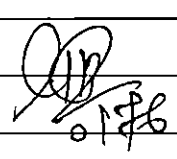
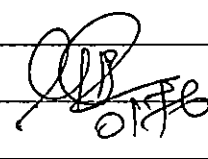
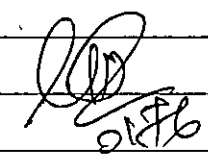
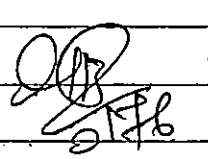
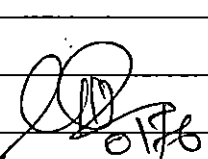
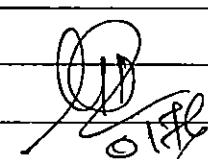
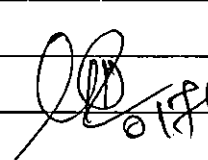
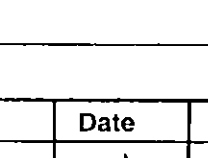
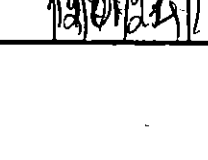
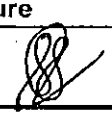
MHI/HOSP/2022/118

Mr. munusamy
64 yrs M
MHI 202481678
Dr. Gnanavelu

Mr. MUNUSAMY
64/Male/MHI202481678
12/01/2024/IPH2024000106
Dr. G. GNANAVELU

MHI/NUR/2022/048

NURSES PROGRESS

Date & Time	Observations / Action	Signature with Emp. No.
12/1/24	Cath lab	
14.50	→ Pt Received from 2nd floor to Cath lab. conscious and oriented. → vitals stable. IV line Rt and left side Patent. VIP score 015	 0176
15.00	→ IVE: NS 20ml/hr IV started O/B Dr. G. Gnanavelu	 0176
16.10	→ Sterile drapping done. PTCA Procedure started.	 0176
16.20	→ Rt Radial arterial approach under local anaesthesia.	 0176
16.25	→ IJ: NTU 200 mcg + IJ: Heparin 5000 ^U IA given O/B Dr. G. Gnanavelu	 0176
16.30	→ BP: 171/91 (122) mmHg, HR: 66 b/min SpO2: 100%. vitals stable.	 0176
16.35	→ IJ: Heparin 2500 ^U IV given O/B Dr. G. Gnanavelu	 0176
16.45	→ BP: 172/98 (124) mmHg, HR: 68 b/min SpO2: 100%. vitals stable.	 0176
17.05	→ JACT - 259 sec checked.	 0176
17.10	→ IJ: Heparin 1000 ^U IV given O/B Dr. G. Gnanavelu	 0176
17.15	→ Procedure PTCA to PEA done. Rt Radial arterial Sheath removed. tight platel bandage applied. no oozing & hematoma	0176
17.25	→ Pt shifted to CCU all reports hand over to Rn mohan	0176
Document endorsed by	Signature 	Name Sathiyar
	Emp. No. 0016	Date 12/01/24 Time 17.25

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

Mr. Munusamy
64 yrs / m
MH 2024 81678
Dr. Gnanavelu

MHI/OT/2022/086



Every heart beat counts

Mr. MUNUSAMY

64 / Male / MHI202481678

12/01/2024 / IPH2024000106

Dr. G. GNANAVELU



Name of the Procedure : PTCA Location : Cath Lab Date & Time : 12/1/24

Does the Procedure involve Procedural Sedation : ☐ Yes ☒ No

SIGN IN <u>16.10</u> Before Induction of Procedural Sedation		TIME OUT <u>16.20</u> After procedural Sedation and before procedure		SIGN OUT <u>17.15</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 <u>PTCA</u> <input checked="" type="checkbox"/> Yes	
Procedure	<input checked="" type="checkbox"/> Yes	Procedures <u>PTCA</u>	<input checked="" type="checkbox"/> Yes	Name and site of all specimens / investigations <input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	
Side	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	Side <u>Rt Radial arterial approach</u>	<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 <u>Supine</u>	<input checked="" type="checkbox"/> Yes	Any recovery concerns : <input type="checkbox"/> Yes <input checked="" 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 :	
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		
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		
All concerned anesthesia equipment and medication check complete	<input checked="" type="checkbox"/> SpO2 <input checked="" type="checkbox"/> NIBP <input checked="" type="checkbox"/> Others pls. specify <u>ECG</u>	Antibiotic prophylaxis within last 60 minutes	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
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	Any Equipment / instrument problem that needs to be addressed : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
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	If Yes, Pls. specify :	
		Anticipated duration briefed	<input checked="" type="checkbox"/> Yes		
		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		Corrective action :	
		Any patient specific concerns :	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
		Intra procedure glycaemic control	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Any concerns about sterility	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		

Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure :	Nurse : <u>R.N. Panthani</u>	Technician : <u>Mr. Ram</u>	Others Please Specify :
Date : <u>12/1/24</u>	Date : <u>12/1/24</u>	Date : <u>12/1/24</u>	Date : <u>12/1/24</u>	Date : <u>12/1/24</u>
Time : <u>15.25</u>	Time : <u>17.25</u>	Time : <u>17.25</u>	Time : <u>17.25</u>	Time : <u>17.25</u>

Procedure Monitoring Sheet (Cath Lab)

Patient Name : **Mr. MUNUSAMY**
64/Male/MHI202481678
12/01/2024/IPH2024000106
UHID / IP : **Dr.G. GNANAVELU**
Consultant :

Age / Sex : **64Y/M**
Ward Unit : **11ND FLOOR**
Diagnosis : **CAD - 1 LOMI**

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

PARAMETERS	YES	NO	NA
Vital signs : BP: 164/70 Temp: 97 ... Pulse: 80 .. RR: 22 .. SPO2: 97	✓		
Urine voided	✓		
Bowel preparation	✓		
Pre-procedure medication administered		✓	
Procedure site marked	✓		
Skin preparation done	✓		
NPO 800pm	✓		
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 : [Signature]	Date & Time : 12/1/24 at 12.10		

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

Time	HR / min	RR / min	BP mmHg	SpO2%	Medication / Remarks	Sign. of Nurse
12/1/24 16.10	72 b/min	22 b/min	168/104 (132)	100%	-	[Signature]
16.20	66 b/min	22 b/min	171/91 (122)	100%	-	[Signature]
16.45	70 b/min	22 b/min	160/95 (112)	100%	-	[Signature]
17.00	70 b/min	22 b/min	175/96 (114)	100%	-	[Signature]
17.15	78 b/min	20 b/min	168/88 (100)	100%	-	[Signature]
Procedure got over						

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

Time : 17.25 Route : Rt Radial arterial approach
 Complication : nil

BP : 168/88(102) mmHg, HR : 70 b/min, RR : 22 b/min SpO2 : 100%

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

Advise:

- ◆ Shift To: Ward / ICU
- ◆ Bed rest up to 6 hours
- ◆ Observe puncture site for bleeding
- ◆ Watch for Pulse in Rt Radial artery.
- ◆ Diet Normal

- ◆ 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 Radial arterial dressing on 13/1/24 at 16.00 AM /PM after informing to the consultant.

- ◆ Special instruction if any: nil

[Signature]
 Name & Signature of Consultant

POST PROCEDURE OBSERVATION

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse

Nurses Notes :

procedure PTCA alone. Rt Radial arterial
 & heath removed. Tight plaster bandage applied
 no oozing & hematoma

Condition at the end of procedure : ☒ Stable ☐ Critical

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

Name & Signature of the Nurse :

Date & Time : 12/1/24 @ 17.25

[Signature]

NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 12/1/24 Time of Arrival: 12:30 Mode of Admission: ☒ Walking ☐ Wheelchair ☐ Stretcher
Accompanied by Relative: ☒ Yes ☐ No If Yes, Name of the Relative: _____
Relationship with Patient: _____ Contact Person's Name: MRS. Dini Relationship: Daughter
Contact No.: 9094060419 Primary language spoken: ☐ Tamil ☐ English ☒ Indian ☐ International
Interpreter needed: ☒ Yes ☐ No Patient status: ☒ Conscious ☐ Unconscious ☐ Disoriented
Menstrual History: LMP: _____ Menopause: _____ Patient Vulnerable: ☒ Yes ☐ No
Medical History: DM / HTN / Co - Morbidity: 2 yrs If Yes, specify _____
Drugs History: Antiplatelet _____ (Specify) _____

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

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than one half of the days	Nearly every day	Total
1. Little Interest or pleasure in doing things	<u>0</u>	1	2	3	<u>0</u>
2. Feeling down, depressed, or hopeless	<u>0</u>	1	2	3	

Scoring: A PHQ-2 score ranges from 0 to 6; patients with total score of 3 or more should be further evaluated with Columbia-suicide Severity Rating Scale (C-SSRS) tool.

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: 97.1 (°F) | Pulse / HR: 70 (beats/min) | BP: 163/97 (mmHg)
Respiration: 24 (breaths/min) | SpO₂: 97.1 (%) | CBG: 89 (mg/dl) | Height: 165 (cms) | Weight: 70 (kgs)

Allergies / Adverse Reaction: ☐ Yes ☒ No ☐ Medication ☐ Blood Transfusion ☐ Food ☐ Not known
If Yes, specify: _____

Pain: ☐ Yes ☒ No. If Yes, Score: 0/10 Pain Scale Used: ☐ NRS (>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: Normal diet
Dietician Informed: ☒ Yes ☐ No. If Yes, mention the Name: MRS. Catherine Time: 12:30

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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<u>Contract (2020)</u>	
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		

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: 23 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
Ambulatory Aid None / Bed Rest / Nurse Assist Crutches / Cane / Walker Furniture		0
		15
		30
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0
	Yes	20
Gait Normal / Bed Rest / Wheel Chair Weak Impaired		0
		10
		20
Mental Status Oriented to own stability Overestimated or forgets limitations		0
		15
Medications Includes PCA / opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, hypoglycemics, sedatives, immunosuppressant and psychotropics	No	0
	Yes	15
Score Interpretation: 0-24: Low-risk; 25-44: Medium Risk; Above 45: High Risk		
Total Score		<u>30</u>

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
- ☒ Advise 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"/>	

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):

Tick the score obtained (✓)

Final Score

		✓	Action Taken	Date	Time
Low Risk	-2 to 0				
Moderate Risk	1 to 2		1 to 2	12/1/24	12:30
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 type="checkbox"/> Yes <input checked="" 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
	S. Devi	S. DEVI	Relationship	12/1/24	12:30
Nurse	<i>[Signature]</i>	R. Srinivas	0801	12/1/24	12:30
Unit In-Charge	<i>[Signature]</i>	S. Nalini	0024	12/1/24	12:30



PATIENT CLINICAL-HANDOVER RECORD FOR NURSES

Date: 12/1/24 Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - Iwmi
NEWS / PEWS Score:
Ventilator day:
Peripheral line day: Right:
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:
Allergies if any: NKA
On room air / oxygen: RA
Complaints / New Symptoms in last shift:
Date of surgery:
IV fluids on flow:

A

ASSESSMENT

Vital Signs: Temp 97.3 (°F) | Pulse / HR: 82 (beats/min) | Respiration: 16 (breaths/min)
BP: 130/80 (mmHg) | SpO₂: 99 (%) | Height: 165 (cms) | Weight: 70 (kgs) | BMI: 22.6 kg/m²
Others:
Pain Score: 0/10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT
Fall Risk Score: 5 Fall Risk Protocol: ☐ Low ☐ Medium ☒ High
Braden Score: ☒ Minimal Risk: 23-19 ☐ At Risk-Mild Risk: 18-15 ☐ Moderate Risk: 14-13 ☐ High Risk: 12-10 ☐ Severe Risk: 9-6
Pressure Ulcer Scale for Healing (PUSH): ☐ Yes ☐ No ☒ NA Wound Dressing done: ☐ Yes ☐ No ☒ NA
Current diet: Normal 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:

	Signature	Name	Emp. No.	Date	Time
Handover given by		R. Sushma	0001	12/1/24	14:30
Handover taken by		Ravitha	0156	12/1/24	14:50
Document endorsed		S. Valsaraj	0004	12/1/24	16:00

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 12/1/24

Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD - IHD / SHITN

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: BRACHIAL Left: BRACHIAL

Ryle's Tube: ☐ Yes ☒ No

Urinary Catheter: ☐ Yes ☒ No

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: -

Date of surgery: -

Allergies if any: NKDA

On room air / oxygen: RA 99%

IV fluids on flow: -

Complaints / New Symptoms in last shift: -

A

ASSESSMENT

Vital Signs: Temp: 97.3 (°F) | Pulse / HR: 86 (beats/min) | Respiration: 20 (breaths/min)

BP: 120/73 (mmHg) | SpO₂: 99 (%) | Height: 165 (cms) | Weight: 70 (kgs) | BMI: 22.4 kg/m²

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: N diet

Drains: -

R

RECOMMENDATION

Referral doctors: Nil

Pending medications: -

Pending medication indent: -

Pending lab reports / Investigations: urea, Creatinine due

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: Todo Screening Echo. Plan for ward shift.

	Signature	Name	Emp. No.	Date	Time
Handover given by		Madhumitha	0244	13/1/24	7:30
Handover taken by		Alathya	0240	13/1/24	7:30
Document endorsed		S. V. P. N. P.	0021	13/1/24	16:00

NURSES PROGRESS NOTES

[illegible]



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 13/1/24 Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - ILM/STN
NEWS / PEWS Score: -
Ventilator day: -
Peripheral line day: Right: brachial Left: brachial
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: P20 DTCA - RCA
Allergies if any: MRDA
On room air / oxygen: RA - 99%
Complaints / New Symptoms in last shift: -

Date of surgery: P20 12/1/24
IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 99 (beats/min) | Respiration: 20 (breaths/min)
BP: 144/92 (mmHg) | SpO₂: 99 (%) | Height: 165 (cms) | Weight: 70 (kgs) | BMI: 22.6 kg/m²
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: (A) diet Drains: -

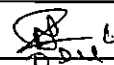
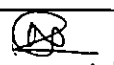
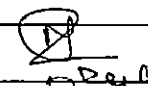
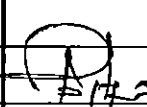

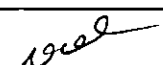
R

RECOMMENDATION

Referral doctors:
Pending medications: Nil
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: tomorrow plan discharge

	Signature	Name	Emp. No.	Date	Time
Handover given by		N. Arthya	0240	13/1/24	1030
Handover taken by		B. Vanish	0195	13/1/24	1030
Document endorsed		S. Velpa	0024	13/1/24	1030

NURSES PROGRESS NOTES

Date & Time	Observations / Action	Signature with Emp. No.
13/1/24	<u>Morning duty Notes.</u>	
7:30	⇒ pt taken over from Night duty staff, pt conscious & oriented, pt vital P ₁ HR-102/mt, spo ₂ -99%, Bp-144/102 mmHg checked & recorded	
8:00	⇒ pt on Room air. ⇒ had ① diet, medicine given as per drug chart.	
9:00	⇒ pt Pressure bandage Removed, IV line Removed.	
10:30	⇒ pt shifted to ward ①	
	paracetamol tablets Received Notes	
10:30	⇒ patient taken over from CCU Staff Nurse ⇒ patient conscious & oriented ⇒ patient T/P Chart monitored ⇒ patient vital signs checked & recorded	
12:30	⇒ patient handing over to Evening duty Staff Nurse	
Document endorsed by	Signature 	Name S. NABAP
	Emp. No. 0004	Date 13/1/24
		Time 16:10



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 13/1/24

Shift: ☐ Morning ☒ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - I wmi / SHIN

NEWS / PEWS Score: -

Ventilator day: -

Peripheral line day: Right: ~~Back~~ Left: Brachia

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: ^{pro} PTA - PCA

Allergies if any: N/A

On room air / oxygen: on room air

Complaints / New Symptoms in last shift: Nil

Date of surgery: ^{pro} 12/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 98.6°F | Pulse / HR: 99 (beats/min) | Respiration: 20b/m (breaths/min)

BP: 144/92 (mmHg) | SpO₂: 99 (%) | Height: 165 (cms) | Weight: 70 (kgs) | BMI: 22.6 kg/m²

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: (A) 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: Tomorrow plan discharge

	Signature	Name	Emp. No.	Date	Time
Handover given by		E. Cathrine	0207	13/1/24	19:30
Handover taken by		S. Nalini	0024	13/1/24	18:20
Document endorsed		S. Nalini	0024	13/1/24	18:20

NURSES PROGRESS NOTES

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 13/01/24 Shift: ☐ Morning ☐ Evening ☒ Night

S

SITUATION

Diagnosis: CAD - IWM/8 HTN

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: ^{Pro} PCA - RCA

Allergies if any: NKDA

On room air / oxygen: -

Complaints / New Symptoms in last shift: -

Date of surgery: ^{Pro} 12/1/24

IV fluids on flow: -

A

ASSESSMENT

Vital Signs: Temp: 98.6 (°F) | Pulse / HR: 92 (beats/min) | Respiration: 20 (breaths/min)

BP: 110/70 (mmHg) | SpO₂: 99 (%) | Height: 165 (cms) | Weight: 70 (kgs) | BMI: 22.6 kg/m²

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: Normal 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: -

	Signature	Name	Emp. No.	Date	Time
Handover given by	E. Calhoun	E. Calhoun	0207	12/1/24	7.30
Handover taken by	A. Nandhini	A. Nandhini	0170	12/1/24	7.3
Document endorsed	S. Gopal Prasad	S. Gopal Prasad	0024	12/1/24	10.15

[illegible]

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 14/1/24

Shift: ☒ Morning ☐ Evening ☐ Night

S

SITUATION

Diagnosis: CAD - JWM/ISHTN
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
POD:
Central line days:
VIP Score: 05

B

BACKGROUND

Type of surgery: PTCA - PCA
Allergies if any: 1/12/24
On room air / oxygen: on room air
Complaints / New Symptoms in last shift:
Date of surgery: 12/1/24
IV fluids on flow:

A

ASSESSMENT

Vital Signs: Temp 97.8°F | Pulse / HR: 90 (beats/min) | Respiration: 20 (breaths/min)
BP: 120/73 (mmHg) | SpO₂: 97% | Height: 165 (cms) | Weight: 70 (kgs) | BMI: 22.6 kg/m²
Others:
Pain Score: 2/10 Pain Scale used: PIRPS / 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 Wound Dressing done: ☐ Yes ☒ No
Current diet: normal 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 discharge

	Signature	Name	Emp. No.	Date	Time
Handover given by		A. N. Landhini	2170	14/1/24	12.30
Handover taken by		Des Cheryael			
Document endorsed		Dr. Gnanavelu	5024	14/1/24	16.20

[illegible]

ADULT NURSING CARE PLAN


Mr. MUNUSAMY
64 / Male / MHI202481678
12/01/2024 / IPH2024000106
Dr. G. GNANAVELU

MHI/NUR/2022/044

Initial Date: 12/1/24 Time: 12:30		Modified Date: Time:		
Reason for Modification:		Diagnosis:		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION <input type="checkbox"/> Keep NPO <input 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 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 Pt had @ diet N Pt had @ diet	 [Signature] 02/1/24
OXYGENATION <input type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O ₂ <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 ₂ 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 ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ 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 Pt SpO ₂ 96% N Pt on room air	 [Signature] 02/1/24 [Signature] 02/1/24
FLUID & ELECTROLYTES <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 maintain good hydration. E N Pt I/O was maintained	 [Signature] 02/1/24 [Signature] 02/1/24

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY <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-Embotic 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 Pt well mobilized N Pt bed mobilized	 W 02H
ELIMINATION <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 foley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistent / volume / Hemetemeses as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M E Elimination Pattern was good N Pt self voided	 W 02H
SKIN INTEGRITY <input type="checkbox"/> Maintain normal skin integrity <input type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI GRADES OF PRESSURE INJURY <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 Maintained Skin Integrity N Pt maintain skin integrity	 W 02H

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE <input type="checkbox"/> Bed-Bath <input type="checkbox"/> Assist-Bath <input 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 maintained good hygiene N P+ clean & well groomed	 W 02/11/14
SAFETY <input type="checkbox"/> Check ID Band <input type="checkbox"/> IV care <input type="checkbox"/> EJV CENTRAL LINE <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 E Checked & kept N P+ ID band	 W 02/11/14
COMFORT AND SLEEP <input type="checkbox"/> Pain Control <input type="checkbox"/> Sleep Patterns <input type="checkbox"/> Others:	<input type="checkbox"/> Patient will have comfortable sleep <input checked="" 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 Provide clean & comfortable N P+ comfortable position	 W 02/11/14
OBSERVATION <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 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 V/S checked & reviewed N P+ V/S are checked	 W 02/11/14
PSYCHOLOGICAL / SPIRITUAL SUPPORT <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 P+ Psychological support given	 W 02/11/14

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <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 E P + well communication N P + well communication	 (P) 0271 W 0271
SPECIAL INTERVENTIONS <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 E medication given as pr. N P + medication given as per doctor's order	 (P) 0271 W 0271
Endorsed by	Signature	Name	Emp. ID	Date	Time
		S. Valpuri	0024	12/1/24	16:22

ADULT NURSING CARE PLAN

Mr. MUNUSAMY
64/Male/MHI202481678
12/01/2024/IPH2024000106
Dr.G. GNANAVELU

Initial Date: 13/1/24 Time: 8.00		Modified Date: Time:		
Reason for Modification:		Diagnosis: CAD / PwMD		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION <input checked="" type="checkbox"/> Keep NPO <input 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 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 @ diet E pt had @ diet N Pt had @ diet	[Signature] [Signature] [Signature]
OXYGENATION <input checked="" type="checkbox"/> Room Air <input type="checkbox"/> Nasal Cannula / High Flow O ₂ <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 ₂ 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 ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ 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 pt on room air N pt is on room air	[Signature] [Signature] [Signature]
FLUID & ELECTROLYTES <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 Pt had oral Intake E pt had oral Intake N Pt I/O chart maintained	[Signature] [Signature] [Signature]

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY <input checked="" 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-Emboloc 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 P+ mobilize on bed	DSU
			E P+ mobilize on bed	DS
			N P+ well mobilized	PC 0207
ELIMINATION <input checked="" type="checkbox"/> Catheter, bedpan, urinal <input type="checkbox"/> Nasogastric tube <input type="checkbox"/> Bowel movement <input 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-continence 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 / consistent / volume / Hematemesis as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M Pto (N) elimination pattern	DS
			E P+ (N) elimination pattern	DS
			N P+ normal elimination pattern	PC 0207
SKIN INTEGRITY <input checked="" type="checkbox"/> Maintain normal skin integrity <input type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI GRADES OF PRESSURE INJURY <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 checked="" type="checkbox"/> Patient will maintain normal healing status <input type="checkbox"/> Patient will discharge with intact skin integrity	<input checked="" 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 maintain (N) Skin Integrity	DSU
			E P+ Maint (N) Skin integrity	DS
			N Patient maintain normal skin integrity	PC 0207

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE <input checked="" type="checkbox"/> Bed-Bath <input type="checkbox"/> Assist-Bath <input 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 Pt well groomed E pt well groomed N Pt well groomed	[Signature] 02/24/16 [Signature] 02/24/16 [Signature] 02/24/16
SAFETY <input checked="" type="checkbox"/> Check ID Band <input type="checkbox"/> IV care <input type="checkbox"/> EJV <input type="checkbox"/> CENTRAL LINE <input type="checkbox"/> Side rails <input type="checkbox"/> Others:	<input checked="" 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 band E Pt ID band N Pt ID Band	[Signature] 02/24/16 [Signature] 02/24/16 [Signature] 02/24/16
COMFORT AND SLEEP <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 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 provide comfort position E pt provide comfort position N Pt provide comfort position	[Signature] 02/24/16 [Signature] 02/24/16 [Signature] 02/24/16
OBSERVATION <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 Pt vitals checked & recorded E pt vitals checked & recorded N Pt v/s checked & recorded	[Signature] 02/24/16 [Signature] 02/24/16 [Signature] 02/24/16
PSYCHOLOGICAL / SPIRITUAL SUPPORT <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
COMMUNICATION <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 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 on verbal communication E pt on verbal communication N pt on verbal communication	SP 02/07 DC 02/07
SPECIAL INTERVENTIONS <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 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 Medicine given as per drug chart E Medication given as per drug chart N Due drugs are given	02/07 DC 02/07
Endorsed by	Signature	Name	Emp. ID	Date	Time
	<i>veel</i>	S. veel PNP	0024	13/1/24	16:20

ADULT NURSING CARE PLAN

Mr. MUNUSAMY
64 / Male / MH1202481678
12/01/2024 / IPH2024000106
Dr. G. GNANAVELU



MHI/NUR/2022/044



Every heart beat counts

Initial Date: 14/01/24 Time: 8.00


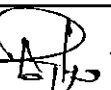


Modified Date: Time:

Reason for Modification:

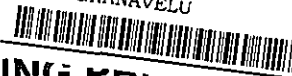
Diagnosis: CAD / IWMPT

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION <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 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 patient had @ Diet E N	[Signature]
OXYGENATION <input type="checkbox"/> Room Air <input checked="" type="checkbox"/> Nasal Cannula / High Flow O ₂ <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 ₂ 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 ₂ saturation and pulse rate <input type="checkbox"/> If any O ₂ 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 patient is on Room Air E N	[Signature]
FLUID & ELECTROLYTES <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 checked="" 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 Chart monitored E N	[Signature]

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY <input checked="" 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 type="checkbox"/> Encourage regular ambulation ROM exercise <input type="checkbox"/> Apply Anti-Embotic 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 <i>patient mobilized well</i> E N	<i>P/2</i>
ELIMINATION <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 toley's / silicone catheter <input type="checkbox"/> Check placement before feeding <input type="checkbox"/> Aspirate NG tube, check colour / consistenct / volume / Hemetemeses as per doctors order and follow proper protocol <input type="checkbox"/> Check for malena / constipation / urinary retention	M <i>Normal Elimination pattern</i> E N	<i>P/2</i>
SKIN INTEGRITY <input checked="" type="checkbox"/> Maintain normal skin integrity <input type="checkbox"/> Pressure points site assessment <input type="checkbox"/> HAPI <input type="checkbox"/> OPI GRADES OF PRESSURE INJURY <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 <i>Maintain Normal Skin integrity</i> E N	<i>P/2</i>

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE <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 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>patient well groomed</i> E N	
SAFETY <input type="checkbox"/> Check ID Band <input type="checkbox"/> IV care <input checked="" type="checkbox"/> EJV <input type="checkbox"/> CENTRAL LINE <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 <i>no band present</i> E N	
COMFORT AND SLEEP <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	
OBSERVATION <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 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>vital signs checked & recorded</i> E N	
PSYCHOLOGICAL / SPIRITUAL SUPPORT <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 <i>psychological support to the pt</i> E N	

Patient Specific Problems / Needs		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
COMMUNICATION <input checked="" 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 <i>Good communication</i> E N	<i>RL</i>
SPECIAL INTERVENTIONS <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 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 <i>Medication given as per drug chart</i> E N	<i>RL</i>
Endorsed by	Signature	Name	Emp. ID	Date	Time
	<i>val</i>	<i>S. val/pnp</i>	<i>0024</i>	<i>14/1/24</i>	<i>16:20</i>



BRADEN SCALE FOR PREDICTING PRESSURE ULCER RISK

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort			
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Barely Moist Skin is usually dry, linen only requires changing at routine intervals			
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours			
MOBILITY ability to change and control body position	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			
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			
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				
					TOTAL SCORE	23	14
					Initial & Emp. No. of Staff Nurse:		
					Initial & Emp. No. of Sr. Staff Nurse:		

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

SENSORY PERCEPTION ability to respond meaningfully 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	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	3	3	3
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	1	1
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	3	3	3
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or 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	3	3	3
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	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	3
TOTAL SCORE					17	17	17
Initial & Emp. No. of Staff Nurse:					0246	02	02
Initial & Emp. No. of Sr. Staff Nurse:					0246	02	02

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

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			
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. Barely Moist Skin is usually dry, linen only requires changing at routine intervals	4			
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4			
MOBILITY ability to change and control body position	1. Completely Immobility 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			
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			
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			
					TOTAL SCORE	23		
					Initial & Emp. No. of Staff Nurse:	Dr. G. Gnanavelu		
					Initial & Emp. No. of Sr. Staff Nurse:	Not		

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

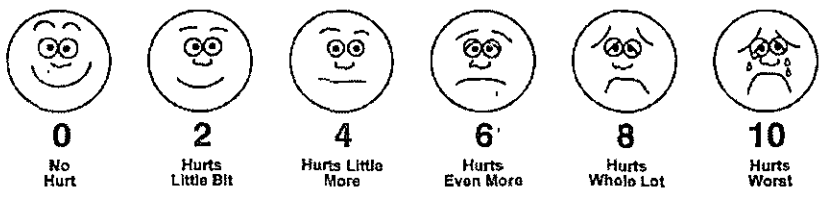
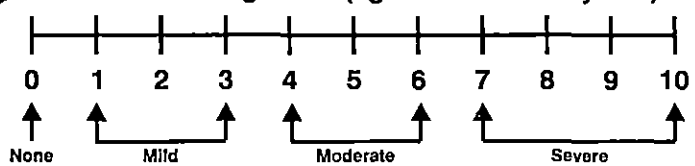


PAIN RE-ASSESSMENT & MONITORING CHART

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.
12/1/24	0/10	No Pain	-	-	-	D 0241	Neel 24
		Pg received from bath lab @ 17.30.					
17.30	0/10	No Pain	-	-	-	D 0241	Neel 24
19.00	0/10	No Pain	-	-	-	D 0241	Neel 24
20.00	0/10	No Pain	-	-	-	D 0241	Neel 24
21.00	0/10	No Pain	-	-	-	D 0241	Neel 24
22.00	0/10	No Pain	-	-	-	D 0241	Neel 24
23.00	0/10	No Pain	-	-	-	D 0241	Neel 24
00.00	0/10	No Pain	-	-	-	D 0241	Neel 24

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
13/11/24 1:00	0/10	No Pain	-	-	-	0244	12/24
2:00	0/10	No Pain	-	-	-	0244	12/24
3:00	0/10	No Pain	-	-	-	0244	12/24
4:00	0/10	No Pain	-	-	-	0244	12/24

PAIN SCALES

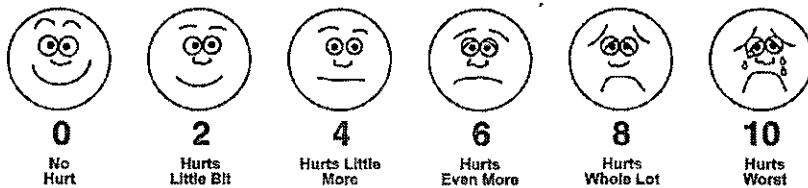
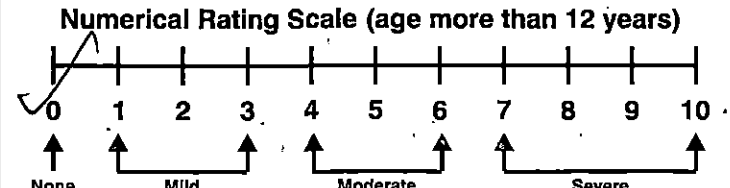
PIPPS (28 weeks to ≤ 38 weeks)	6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures >12 = Moderate to severe pain - Pharmacological intervention	
CRIES (38 weeks - 2 months)	The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. 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 counseling	
Pharmacological Interventions as per doctor's prescription		

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.
13 11:24 5:00	0/10	No Pain	-	-	-	0244	0244
6:00	0/10	No Pain	-	-	-	0244	0244
7:00	0/10	No Pain	-	-	-	0244	0244
8:00	0/10	No pain	-	-	-	0246	0246
9:00	0/10	No pain	-	-	-	0246	0246
10:00	0/10	No pain	-	-	-	0246	0246
11:00	0/10	No pain	-	-	-	0246	0246
12:00	0/10	No pain	-	-	-	0246	0246
13:00	0/10	No pain	-	-	-	0246	0246
14:00	0/10	No pain	-	-	-	0246	0246
15:00	0/10	No pain	-	-	-	0246	0246
16:00	0/10	No pain	-	-	-	0246	0246
17:00	0/10	No pain	-	-	-	0246	0246
18:00	0/10	No pain	-	-	-	0246	0246
19:00	0/10	No pain	-	-	-	0246	0246
20:00	0/10	No pain	-	-	-	0246	0246
21:00	0/10	No pain	-	-	-	0246	0246
22:00	0/10	No pain	-	-	-	0246	0246







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.
14/06/24 2.00				Patient is sleeping			
6.00	0/10	No pain	—	—	—	DL 0807	nee af
10.00	0/10	No pain	—	—	—	DL 0807	nee af

PAIN SCALES

PIPPS (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	
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)	 <p>0 No Hurt</p> <p>2 Hurts Little Bit</p> <p>4 Hurts Little More</p> <p>6 Hurts Even More</p> <p>8 Hurts Whole Lot</p> <p>10 Hurts Worst</p>	Numerical Rating Scale (age more than 12 years)  <p>None Mild Moderate Severe</p>
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	12/1	13/1	14/01/24				
		Time	14:00	2:00	6:00				
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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature & Emp. No. of RN									
Signature & Emp. No. of Sr. RN									



MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	12/1	12/1	12/1	12/1	13/01/24	14/1/24			
	Time	14.00	20.00	8.00	14.00	20.00	8.00			
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		30	50	50	50	50	50			
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

[illegible]



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 checked="" 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>12/1/24</u> Time <u>10:00</u> Nurse Signature : <u>[Signature]</u>		

Learning Record

Need	Date	Visit 1			Date	Visit 2			Date	Visit 3			Signature
		L	P	O		L	P	O		L	P	O	
Disease	12/1				3/1				14/01/24				Doctor
<input checked="" type="checkbox"/> Information on Disease / Diagnostics													[Signature]
<input checked="" type="checkbox"/> Treatment Medications													Doctor / Nurse
<input checked="" type="checkbox"/> Information on Safe and Effective use of medicines													
<input checked="" type="checkbox"/> Information on drug / drug and drug / food interactions													
<input checked="" type="checkbox"/> Discharge Medications													
Surgical Instructions													Nurse
<input type="checkbox"/> Pre - Operative Instructions													
<input checked="" type="checkbox"/> Post - Operative Instructions (Wound / Dressing Care)													[Signature]
Pain Management													Nurse
<input type="checkbox"/> Reporting of pain													
<input type="checkbox"/> Pain Management													
Safe and effective use of medical Equipment (if required)													Doctor / Nurse
Name of Equipment													
Rehabilitation Techniques													

S. Devi

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			P	W			P	W			P	W	Mark Catherine John Senior Dietician
<input checked="" type="checkbox"/> Diet advice for home			P	W			P	W			P	W	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	<input checked="" type="checkbox"/>			Diet Advice	<input checked="" type="checkbox"/>		
ECG Report	<input checked="" type="checkbox"/>			CT Scan Report			
Doppler Report				CT Scan Film			
X-Ray Report	<input checked="" type="checkbox"/>			ECHO Report	<input checked="" type="checkbox"/>		
X-Ray Film	<input checked="" type="checkbox"/>			Ultrasound Report			
Compact Disk	<input checked="" type="checkbox"/>			Any Other Report	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Name of Attendant / Patient : S. DEVI S. Signature : S. Devi


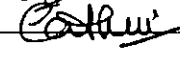
Name of Discharge Nurse Deep for 49 Signature : Deep

Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 12/1/24 Time: 14:00

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

Inter Disciplinary Team Members

	Signature	Name	Reg. / Emp. No.	Date	Time
Doctor					
Nursing Staff		R. Sushma	1061	12/1/24	14:00
Dietician		Dr. G. Gnana Velu Senior Dietician	2407	12/1/24	18:00
Physiotherapist					
Patient Care Service Staff					



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

Mr. MUNUSAMY

64/Male/MHI202481678

12/01/2024/IPH2024000106

Dr. G. GNANAVELU



MHI/IP/2022/054



Every heart beat counts

IN-HOUSE TRANSFER FORM

Part A (to be filled by Nurses)

Date of Transfer: 13/1/24 Time: 11:30 Transferred from: 2nd Floor CCU To: 2nd Floor

Diagnosis:

CAD / IWM / SH7N.

Vital Signs: Temp: 98.6°F | Pulse / HR: 100 (beats/min) | BP: 120/70 (mmHg) | Respiration: 20 (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 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 checked="" 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. ECOSPIRIN	75mg	PO	Q12H	12/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	T. ASPIRIN	90mg	PO	Q12H	13/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	T. NITROGLYCERIN	1mg	SL	Q12H	"	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	T. TRILMA	40mg	PO	Q12H	"	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	T. ATORVASTATIN	40mg	PO	Q12H	12/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6	T. FLAVONOL MON	3mg	PO	Q12H	13/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7	T. NAC (N-Acetylcysteine)	600mg	PO	Q12H	13/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8	T. NITROGLYCERIN	5mg	PO	Q12H	13/1/24	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9	NEB: LEVULIN	1mg	PO	Q12H	"	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10	T. PARACETAMOL	50mg	N	Q12H	"	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
11	T. DIBENICHLIN	200	N	Q12H	"	<input checked="" 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

Additional Details (if any):

Patient Conditions: ☒ Stable ☐ Sick-need urgent care ☐ Others: _____

	Sign.	Name	Reg. No.	Date	Time
Transferring Doctor	<i>1hr</i>	<i>Dr. Khartouk</i>	<i>85851</i>	<i>13/1/24</i>	<i>10:15</i>
Receiving Doctor	<i>K.00</i>	<i>DR. ANUSUYA</i>	<i>134559</i>	<i>13/1/24</i>	<i>10:30</i>

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 type="checkbox"/> Patent <input checked="" type="checkbox"/> Tracheostomy <input type="checkbox"/> Others: _____ Oxygen Therapy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes via: _____ 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: _____ WELLS: _____ NEWS / PEWS: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Patient Belongings	<input checked="" type="checkbox"/> Yes <input 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 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>	<i>Nashira</i>	<i>0240</i>	<i>13/1/24</i>	<i>10:15</i>
Receiving Nurse	<i>[Signature]</i>	<i>B. Vanison</i>	<i>0190</i>	<i>13/1/24</i>	<i>10:30</i>

VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME : **Mr. MUNUSAMY**
64/Male/MHI202481678
12/01/2024/1PH2024000106
AGE / SEX :
Dr.G. GNANAVELU

IP No. / UHID No

Ward / Bed No. **204**

ANY SCORE > 0 SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
12/1/24	5:00	Ant cubital	0/5	Observation	flushed	flushed	02271
	20:00	Brachial	0/5	Patient	flushed	flushed	02271
		PT IV		Line	Removed		
12/1/24							
12/1/24	20:00	Brachial	0/5	Patient	flushed	flushed	02271
	20:00	Brachial	0/5	Patient	flushed	flushed	02271
13/1/24	8:00	Brachial	0/5	Patient	flushed	flushed	02271
	14:00	Brachial	0/5	Patient	flushed	flushed	02271
14/1/24	8:00	Brachial	0/5	Patient	flushed	flushed	02271
	14:00	Brachial	0/5	Patient	flushed	flushed	02271
	20:00	Brachial	0/5	Patient	flushed	flushed	02271
14/1/24	8:00	Brachial	0/5	Patient	flushed	flushed	02271



Medway Hospitals
the way to better health

(A Unit of United Alliance Healthcare Pvt. Ltd.)



Where heart best never stops...

Mr. MUNUSAMY

64/Male/MHI202481678

12/01/2024/IPH2024000106

REQUISITION FOR

Name of Patient

Dr. G. GNANAVELU

Age / Sex



Consultant Name :

IP No. :

DOA :

UHID No. :

Room No. :

S.No.	Date	Medicine Name	Qty.
1	12/01/24	T. FLOXIDIN 150mg	(5)
2	"	T. DEXTRO 150mg	(5)
3	"	T. FLOXIDIN 150mg	(5)
4	"	T. FLOXIDIN 150mg	(5)
5	"	T. FLOXIDIN 150mg	(5)
6	"	T. FLOXIDIN 150mg	(5)
7	"	T. FLOXIDIN 150mg	(5)
8	"	T. FLOXIDIN 150mg	(5)

Nurse Name

Pharm Bill & Name



Mr.MUNUSAMY

64/Male/MH1202481678

12/01/2024/1PH2024000106

Dr.G. GNANAVELU



MHI/PHARM/2022/028



Every heart beat counts


MEDICATION ADMINISTRATION RECORD

Drug Chart: _____ of _____

Height (cms): 165

Weight (kg): 70

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

Drug Details NKDh	Description of Allergy —	Doctor's Sign:  Name: Dr. Anus Reg. No. 134559
---------------------------------	--	---

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: Q24hrly: 10:00hrs, Q12hrly: 10:00hrs, 22:00hrs or 06:00hrs, 18:00hrs, Q8hrly: 06:00hrs, 14:00hrs, 22:00hrs or 09:00hrs, 14:00hrs, 21:00hrs, Q6hrly: 05:00hrs, 11:00hrs, 17:00hrs, 23:00hrs, Q4hrly: 02:00hrs, 06:00hrs, 10:00hrs, 14:00hrs, 18:00hrs, 22:00hrs

Stat / Once Only / Premedication Drugs[illegible]

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

DRUG NAME

T. ECOSPRIN

Dose

75mg

Route

P/O

Frequency

0-1-0

Dr. Sign & Reg. No. / Seal

K'm
(Bum)

Start Date & Time

13.1.24

Stop Date & Time

Additional Info:

DRUG NAME

T. AXER

Dose

90mg

Route

P/O

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

K'm
(Bum)

Start Date & Time

12.1.24 20.00

Stop Date & Time

Additional Info:

DRUG NAME

T. NITRO GLYCERIN

Dose

2-6mg

Route

P/O

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

K'm
(Bum)

Start Date & Time

12.1.24 20

Stop Date & Time

Additional Info:

DRUG NAME

T. TELMA

Dose

40mg

Route

P/O

Frequency

1-0-0

Dr. Sign & Reg. No. / Seal

K'm
(Bum)

Start Date & Time

12.1.24 8.00

Stop Date & Time

Additional Info:

DRUG NAME

T. PANU

Dose

40mg

Route

P/O

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

K'm
(Bum)

Start Date & Time

12.1.24 7.00

Stop Date & Time

13/1/24 @ 9.00

Additional Info:

BEFORE FOOD.

Area In-charge

Nurse Signature:

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

T. ATORVAST

Dose

40mg

Route

P/O

Frequency

0-0-1

Dr. Sign & Reg. No. / Seal

K'bn
134579

Start Date & Time

12/1/24 at 20:00

Stop Date & Time

20:00

20:30 20:30
20:30 20:30

Additional Info:

DRUG NAME

T. FLAVESDON MR

Dose

35mg

Route

P/O

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

K'bn
134579

Start Date & Time

12/1/24 at 20:00

Stop Date & Time

20:00

20:30 20:30
20:30 20:30

Additional Info:

DRUG NAME

T. MAC

Dose

600mg

Route

P/O

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

K'bn
134579

Start Date & Time

12/1/24 at 20:00

Stop Date & Time

20:00

20:30 20:30
20:30 20:30

Additional Info:

DRUG NAME

T. NIKORAN

Dose

5mg

Route

P/O

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

K'bn
134579

Start Date & Time

12/1/24 at 20:00

Stop Date & Time

20:00

20:30 20:30
20:30 20:30

Additional Info:

DRUG NAME

Nes- 2200 LIN

Dose

1mg

Route

PLN

Frequency

1-1-1

Dr. Sign & Reg. No. / Seal

K'bn
134579

Start Date & Time

12/1/24 at 20:00

Stop Date & Time

20:00

20:30 20:30
20:30 20:30

Additional Info:

Area In-charge

Nurse Signature:

Nes- 2200 LIN
20:00 20:00
20:00 20:00

REGULAR PRESCRIPTIONS

To be filled in by Doctors only

Date →

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

Time ↓

13/11/24

DRUG NAME

2i RANTAC

8:00

7:30
P.S.

Dose

50mg

Route

IV

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

13/11/24 @ 19:50
35851

Start Date & Time

13/11/24 @ 19:50

Stop Date & Time

19:00

20:00
P.S.

Additional Info:

DRUG NAME

Reg. DERIPHYLIN

8:00

7:30
P.S.

Dose

2cc

Route

IV

Frequency

1-0-1

Dr. Sign & Reg. No. / Seal

13/11/24 @ 19:30
9724

Start Date & Time

13/11/24 @ 19:30

Stop Date & Time

20:00

20:00
P.S.

Additional Info:

DRUG NAME

neb. DUOLIN-

8:00

Dose

1 neap

Route

neb

Frequency

1-1-1

Dr. Sign & Reg. No. / Seal

Start Date & Time

13/11/24 @ 14:00

Stop Date & Time

13/01/24

20:00

Additional Info:

DRUG NAME

Dose

Route

Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

DRUG NAME

Dose

Route

Frequency

Dr. Sign & Reg. No. / Seal

Start Date & Time

Stop Date & Time

Additional Info:

Area In-charge

Nurse Signature:

13/11/24

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

Clinical Pharmacist
Medway Heart Institute

[illegible][illegible]

DIET ORDERS (to be prescribed by Doctors only)

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
12/12/24	8:00	Normal diet-	[Signature]	9546					
13/1/24	8:00	(A) diet	[Signature]	65851					
14/1/24	8:00	Normal diet	[Signature]	134774					

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			
12/12/24	Night	Madhumitha	0244	K.		Night			
13/1/24	Morning	Alathiya	0240	[Signature]		Morning			
13/1/24	Evening	A. ALBINUS	0088	[Signature]		Evening			
13/1/24	Night	F. Cathrine	0208	F.C		Night			
14/1/24	Morning	B. Vanis	0195	[Signature]		Morning			
	Evening					Evening			
	Night					Night			
	Morning					Morning			
	Evening					Evening			
	Night					Night			

12 W M 2

MHT/ICU/2022/064



13 11 | 2H - 2(2)

[illegible]

MHI/ICU/2022/064



Mr. MUNUSAMY

64/Malc/MHI202481678

12/01/2024/IPH2024000106

NAME Dr.G. GNANAVELU

BLOOD GROUP .

INTERMEDIATE CARE FLOWCHART

B

UHID NO :

AGE : 64

SEX : M

202481678

HEIGHT : 165 cm

WEIGHT: 70K g

B.S.A: 1.2 m^2

1311/2H - 2

[illegible]

PREVIOUS DAY - HOURS

DRAINAGE

URINE $\Rightarrow 2100 \text{ m}$

TOTAL INTAKE $\Rightarrow 900 \text{ ml}$

TOTAL OUTPUT $\Rightarrow 2100 \text{ ml}$

BALANCE $\rightarrow 1200 \text{ ml}$

Δ¹² - CAD / EWMR / SHTN - /

MHI/ICU/2022/064



Mr. MUNUSAMY

64/Male/MHI202481678

12/01/2024/IPH2024000106

NAME : Dr.G. GNANAVELU

UHID NO :

AGE :

SEX :

A

SURGICAL PROCEDURE : PTCA TO RCA

MHI202481678

64

M.

POSTOP DAY : 0 day

FLUID REQUIREMENT : -

DATE & TIME	URINE		CHEST DRAINAGE				TOTAL OUTPUT	I.V. FLUIDS				ORAL/ R.T.			TOTAL INTEKE	TOTAL BALANCE
	H.T.	G.T.		AIR LEAK	H.T.	G.T.		255				H.T.	H.T.	G.T.		
17.30	-	-					-	90				-	200		250	+200
18.30	-	-					-	10				110	350		450	+400
19.30	-	-					-	50				-	300		500	+500
20.30	500	500					500	50				100	450		650	+150
21.30		500					500	50					450		900	+200
22.30		500					500	50				100	550		850	+350
23.30	500	1000					1000	R/C					550		850	-150
00.30		1000					1000						550		850	-150
1.30	400	1400					1400						550		850	-550
2.30		1400					1400						550		850	-550
3.30		1400					1400						550		850	-550
4.30	400	1800					1800						550		850	-950
5.30	300	2100					2100						550		850	-1250
6.30		2100					2100						550		850	-1250
7.30		2100					2100					50	600		900	-1200

SPECIFIC OBSERVATIONS/REMARKS

MEDICATION / DRUGS

OLD PTB / OLD CNA



MHI/ICU/2022/064

Mr. MUNUSAMY

64/Male/MHI202481678

12/01/2024/IPH2024000106

NAME : Dr.G. GNANAVELU



BLOOD GROUP : —

IMMEDIATE CARE FLOWCHART

B

UHID NO :

AGE :

SEX :

MHI202481678 64 M

HEIGHT :

165 cm

WEIGHT :

70 kg

B.S.A :

1.2 m²

HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS / OTHER DATA
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	
18.0	92	Reg	98%	132/80	110	Warm	++	26	Bld	98%	On room air
19.0	90	Reg	98%	132/80	124	Warm	++	27	Bld	98%	"
19.30	69	Reg	98%	136/106	131	Warm	++	29	Bld	98%	"
20.30	41	Sinus	97%	167/102	124	Warm	++	32	Bld	98%	"
21.30	42	Sinus	97%	156/99	117	Warm	++	24	Bld	98%	"
22.30	42	Sinus	97%	162/110	110	Warm	++	28	Bld	97%	"
23.30	80	Sinus	97%	140/108	120	Warm	++	24	Bld	98%	"
00.30	83	Sinus	97%	156/94	115	Warm	++	28	Bld	97%	"
1.30	84	Sinus	97%	150/103	119	Warm	++	24	Bld	98%	"
2.30	82	Sinus	97%	156/94	115	Warm	++	25	Bld	96%	"
3.30	83	Sinus	97%	150/103	119	Warm	++	22	Bld	98%	"
4.30	46	Sinus	97%	168/100	123	Warm	++	20	Bld	98%	"
5.30	44	Sinus	97%	163/94	117	Warm	++	22	Bld	97%	"
6.30	92	Sinus	97%	168/100	123	Warm	++	23	Bld	96%	"
7.30	40	Sinus	97%	144/101	125	Warm	++	24	Bld	98%	"

PREVIOUS DAY - HOURS

DRAINAGE

TOTAL INTAKE

URINE

TOTAL OUTPUT

BALANCE