

MRD CHECKLIST

PARTICULARS	YES	NO
- IP Number allocated to each Patient	5	
- Name, Age & Sex of Patient	- N	
- General Admission Consent	2	
- Initial Assessment of Patient / Diagnosis	5	
- Nutritional Assessment by Consultant	∽	
- Plan of care counter signed by the Consultant	γ	
- Treatment Orders - Date, Time, Name & Sign.	5	
- Medication Order / Drug Chart - Date, Time, Name & Sign.	~	
- Vital Signs Chart (TPR Chart)	5	
- Intake Output Chart	~	
- Drug Chart (Duly filled)	<i>a</i>	
- Anesthesia Consent - (8 thing) - Date, Time, Name & Sign. of both Patient & Anesthetist	~	
- Anesthesia Assessment Sheet	<u> </u>	
- Surgery Consent - (8 things) - Date, Time, Name & Sign of both Patient & Surgeon	m	
- Surgery Notes - Post Operative Plan		
- Pain Scoring System		
- Blood Transfusion if done		
- High Risk Procedures		
- A copy of the Discharge Summary	V	

Medway Hospitals

Mr.KALIYAN S

71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ



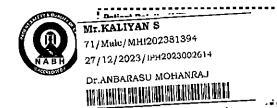


The way to better health (A Unit of United Alliance Healthcare Pvt Ltd) A A A
Admitting Doctor: Speciality: Speciality: Speciality:
Advised Date & Time: 2 7 11 23 (0) (158am. 12:15Ph
Provisional Diagnosis:
CAD-TVD/T2DM/HTN/ Dyslepidencia.
Reason for Admission: Medical Management Surgical Management
Others (please specify details)
Admission Type: Day Care DER Ward
LCU (Specify details)
Surgery / Procedure Name (if planned):
CABY.
Blood Product Requirement: No Yes (Kindly specify details of components required in space below)
Expected Duration of Stay: 5 - 6 acres
Expected Cost of Treatment (as per Financial Counseling Form):
Payer: Self Insurance Others:
Instructions to Nurse (if any):
-> Admit in semi Privale
vaid.
Any other Instructions (if any):
Donton Signature Violan Reg. No. Dr. ANBARASU WOHANRAJ 55476 Reg. No: 55476 Reg. No: 55476

For admission desk staff of	only:		, ,
	General Ward Single Room Twin Sharing Deluxe Room Suite Room Others		
Admission intimation	Receipt Details	Admission T	me in HIS
Date	Time	Date	Time
2 1/1/23	12.1800	27/12/23	12'.15 pg
To be filled only if Blood	OPD ER Direct requirement specified by the	/	
is blood Reservation and	i Blood Bank clearance com	pieted as advised: 🗾 Yes	☐ No
Front office Staff Signature	Name PLanelley	Emp. No. 7 MH/0273	Date, Time 27/14/23 1 2. 15/
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Medway Hospitals The way to better health (A Unit of United Alliance People.)





ADMISSION FORM

Marital Statu	Full Address	Telephone Number
matry	Thoroughan and in (P. D) Curido Care	Ď-т D
Occupation CRBV7	S. Kaliyan Theorthanagiri (P.0) Cudalore() Pin 1-608801	9486659113
Referred from	Date of Time of Admission Date & Time of Discharge	Diai No. of Days
Mr. DL	n Date of Time of Admission Date & Time of Discharge To Admission Date & Time Date & Discharge To Admission Date & Discharge To Ad	¥
UNIT	NIO DIVIN DIVIN INVO ADNO A	
Cardio	othoroucic MLC Yes No If Yes AR No.:	,
	FINAL DIAGNOSIS	ICD Code
TRIPL	E VESSEL CORONARY ARTERY DISEASE , CRITICAL	25.1
LEFT	MAIN DISEASE, POSITIVE TMT, CLASS II III ANGI	NA 1294.3 11208
NORM	1AL LU SYSTOLIC FUNCTION -EF-601.	50.1
Ty	RE I DIABETES MELLITUS, SYSTEMIC HYPERTO	rsion Fina IIIo
	Dysupidenia.	F18.5
-		
DATE	OPERATION / PROCEDURES	ICPM Code
	OFF PUMP CORONARY ARTERY BYPASS	36.13
28/12/2	CRAFTING & 3 GRAFTS.	
DATE	TYPE OF ANESTHESIA	-
2812123	GENERAL SPINAL LOCAL REGIONAL	☐ EPIDURAL
	DISCHARGE STATUS	
□ Cured	☐ Discharge at Request ☐	Expired < 48 hours
☐ Improve	☐ Against Medical Advice d ☐ Absconded ☐	Expired > 48 hours
□ Phychaig		Post-Operative Death
. F	Reg No: 55476	₹D
Signature	of the Consultant Signature of Me	dical Records Officer

AUTHORISATION FOR TREATMENT I PAYMENT

I hereby authorise the Administration, Medical and Nursing and Paramedical, Staf f of the Hospital Investigate treat and administer such drugs as may be necessary and to perform such operation under anaesthesia or other wise as may be deemed necessary and / or advisable in the diagnosis and treatment of my illness / patient. 5 Kalifornia who is my ... Total ... (Relationship).

I hereby under take to settle all the bills for hospitalisation charges related to me/the patient named overleaf on a periodic basis. In any case, I shall pay all the dues before getting discharged from the hospital. However, in case I fail to pay the charges due to the hospital as agreed above, I hereby authorise the hospital to transfer me/the patient to any other hospital/institution for further treatment as deemed fit and proper by the hospital authorities. I also acknowledge having been informed if the General Rules and Regulations of the Hospital and that all cash, jewellery and valuables belonging to the patient or their attendants have been removed to a place of safety / handed over to the next of kin and I absolve the hospital of any responsibility with regard to any loss. I have read out and explained the contents of the above to the Signatory in his vernacular . சிகீச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல் இதன் மூலமாக நான் நீர்வாகம், மருத்துவம், தாதீயர், ஏனைய மருத்துவ ஊழியர்கள் எனக்கு / நோயாளிக்கு தேவைப்பட்ட சோதனைகளை செய்து மருந்துகளை கொடுக்கவும். மயக்க மருந்துகள் கொடுத்து செய்முறைகள்/அறுவை சிகீச்சை செய்யவும் அதீகாரம் வழங்குகீறேன். நான் / இதீல் குறித்துள்ள நோயாளின் செவைக்கன தொகை முழுவதும் செலுத்த இதன் மூலம் உறுதி அளிக்கிறேன். மேல் கூறியது போல் வேளை நான் தங்கள் மருத்துவத்திற்கான செலவுகளை கட்டத் தவறினால் என்னை நோயாளியை வேறொரு மருத்துவமனைக்கு, பிற சிகீச்சை / அறுவை சிகீச்சை செய்ய இடமாற்ற ஒப்புதலை எனது உறவினர்கள் மூலமாக பெற நான் அதிகாரம் அளிக்கீறேன். மருத்துவமனையின் பொது சட்ட தீட்டங்கள் பற்றி தெரிவிக்கீப்பட்டிருக்கீறேன். நோயாளிக்கு உரிமையான எல்லா பணம், நகை மதிப்பிடக்கூடி பொருட்கள் யாவும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்லு நெருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ளது. இந்த மருத்துவமனை எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை என உறுதி செய்கீறேன். மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன். C55 27 12/23 எனது/உறவினர்/காப்பாளர் கையொப்பம் Signature of the Patient / Relative / Gurdian Signature of Admitting Nurse Date

\$ Father in Can

உறவுமுறை

Nature of Relationship

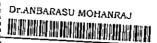


discharge.





Mr.KALIYAN S 71/Male/MHI202381394 27/12/2023/IPH2023002614





GENERAL CONSENT FOR ADMISSION

•	SILADI YAN the Patient or Representative of patient have please tick the correct option above and below)
I,	the Patient or Representative of patient have
\/	□ 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.
٠,	
•	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
٠	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
٠	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

- 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.

		<u> </u>		
	Signature / Thumb Impression*	Name	Date	Time
Patient	1.S. poly	5.12 aliyan	27/12/23	12:15
Surrogate/Guardian (if applicable #)	G. Smuy-	(Write name and relationship with patient)	27/12/23	1275
Reason for surrogate consent	Patient is unable to give consent	because:		 [
Witness	k. gam	k. SARAVANAN	27/2/2)	12:157
Interpreter (if applicable)				

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



Mr.KALIYAN S

71/Malc/MHJ202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ





Every heart beat counts

ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

<u> </u>	ADMINGION ON LINE ON THE CANAL ON THE COMME		
S.	PARAMETERS	MARK ✓ AS APPROPRIATE	
No.		APPHO	TRIAIE
	Hemodynamic instability defined as		
	Pulse less than 40 or more than 150 beats/minute		
4	Systolic arterial pressure less than 80 mm Hg or 20 mm Hg below the patient's usual pressure		
•	Mean arterial pressure less than 60 mm Hg		
	Diastolic arterial pressure more than 120 mm Hg		_
	Respiratory rate more than 35 breaths/minute		
- 			
	Cardio-vascular System		ľ
	Acute myocardial infarction		
	Cardiogenic shock ,		
	Complex arrhythmias requiring close monitoring and intervention		
_	Acute congestive heart failure with respiratory failure and / or requiring hemodynamic support		ļ
2	Hypertensive emergencies		
	Unstable angina, particularly with dysrhythmias, hemodynamic instability, or persistent chest pain		<u> </u>
	Post cardiac arrest		
	Cardiac tamponade or constriction with hemodynamic instability		
	Dissecting aortic aneurysms		
	Complete heart block		
	Miscellaneous Conditions		
	Septic shock with hemodynamic instability		
3	Hemodynamic monitoring		
	Clinical conditions requiring ICU level nursing care		
	Post procedure elective admission		
4	Post Coronary Angioplasty		
)	Post Cardio-vascular Surgery .	7	
	Following angiographic procedure		
	Complication resulting from the angiographic procedure including any significant change in pulse in the	ļ	
	affected extremity, neurologic changes, persistent bleeding, or persistent nausea and vomiting post-		
5	procedure		
	Significant findings on diagnostic angiography warranting further therapy that would necessitate inpatient		
.	admission is also a reasonable indication for admission		· · · ·
	Admission at the time of the study is encouraged if problems are suspected or arise	(
	Pulmonary System		
	Acute respiratory failure requiring ventilatory support (Invasive / Non-Invasive)		
	Pulmonary emboli with hemodynamic instability		
ا ۾	Patients in an intermediate care unit (HDU / Recovery room) who are demonstrating respiratory		
6	deterioration		
	Need for nursing / respiratory care not available in such intermediate care units		
į	Massive hemoptysis	<u> </u>	
İ	Respiratory failure needing imminent intubation		
	Renal failure	· .	
- 1	Oliguria or anuria for more than 12 hours		
7	Metabolic acidosis (pH < 7.1)		<u> </u>
	Patients requiring hemodialysis can be performed in ICU when the blood pressure is borderline		
	Talletta Joquita griphical algoritoria de portoria de atributa la como de posso de la como	. 1	

S. No.	PARAMETERS					K ✓ AS OPRIATE
,	Endocrine System and Metabolism related Diabetic ketoacidosis complicated by hemodynamic instability, altered mental status, respiratory insufficiency, or severe acidosis					
		storm or myxedema coma wi				
			r hemodynamic instability or Serum Gluco drenal crises with hemodynamic instability			
8	Severe		lcium more than 15 mg/dl) with altere		ing	
		hypernatremia (Serum Sodiu	um less than 110 mEq/L or more than 155	mEq/L) with seizures, alte	red	
			odynamic compromise or dysrhythmias			
		hyperkalemia (Serum Potass ar weakness	sium less than 2.0 mEq/L or more than 6.0	mEq/L) with dysrhythmias	sor	
		osphatemia with muscular w	eakness			
	<u> </u>	Signature	Name	Reg. No.	Date	Time
Do	cior	٢	Dr. pravce	m 112216	28/12/21	12.4
•						
- <u></u> S.	DIS	CHARGE CRITE	ERIA FOR INTENSIVE	CARE UNIT	MAR	 K √ AS
S. No.	DIS	CHARGE CRITE	ERIA FOR INTENSIVE	CARE UNIT		K ✓ AS OPRIATE
No.	Stable	emodynamic parameters	PARAMETERS			
No. 1 2	Stable h Stable r	emodynamic parameters espiratory status (Pt. extubate	PARAMETERS ed with stable arterial blood gases) & airwa			
No.	Stable h Stable r Minima	emodynamic parameters espiratory status (Pt. extubate oxygen requirement (not mo	PARAMETERS ed with stable arterial blood gases) & airwa	ay patent		
No. 1 2 3 4 5	Stable h Stable r Minima Intraver Cardiac	emodynamic parameters espiratory status (Pt. extubate oxygen requirement (not mo nous / Inotropic / Vasopressor dysrhythmias are controlled	PARAMETERS ed with stable arterial blood gases) & airwa ore than 3 L by nasal prongs) r support and vasodilators are no longer ne	ay patent		
No. 1 2 3 4 5	Stable r Stable r Minima Intraver Cardiac Presence	emodynamic parameters espiratory status (Pt. extubate oxygen requirement (not mo lous / Inotropic / Vasopressor dysrhythmias are controlled ce of distal pulses	PARAMETERS ed with stable arterial blood gases) & airwa ore than 3 L by nasal prongs) r support and vasodilators are no longer na	ay patent		
No. 1 2 3 4 5	Stable r Stable r Minimal Intraver Cardiac Presence No sign	emodynamic parameters espiratory status (Pt. extubate oxygen requirement (not mo nous / Inotropic / Vasopressor dysrhythmias are controlled	PARAMETERS ed with stable arterial blood gases) & airwa ore than 3 L by nasal prongs) r support and vasodilators are no longer na	ay patent		
No. 1 2 3 4 5 6 7	Stable r Stable r Minimal Intraver Cardiac Presence No sign	emodynamic parameters espiratory status (Pt. extubate oxygen requirement (not mo ous / Inotropic / Vasopressor dysrhythmias are controlled ce of distal pulses s of bleeding and hematoma	PARAMETERS ed with stable arterial blood gases) & airwa ore than 3 L by nasal prongs) r support and vasodilators are no longer na	ay patent		
No. 1 2 3 4 5 6 7 8	Stable r Stable r Minimal Intraver Cardiac Presence No sign	emodynamic parameters espiratory status (Pt. extubate oxygen requirement (not mo lous / Inotropic / Vasopressor dysrhythmias are controlled be of distal pulses s of bleeding and hematoma fe care pathway chosen	PARAMETERS ed with stable arterial blood gases) & airwa pre than 3 L by nasal prongs) r support and vasodilators are no longer ne at puncture site	ay patent ecessary	APPR	Time

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

DISCHARGE SUMMARY

IP No.

: IPH2023002614

D.O.A

: 27/12/2023

UHID

: MHI202381394

D.O.D

02/01/2024

Name

: Mr. KALIYAN.S

Room No.

104

Age / Gender : 71Years / MALE

Consultant

: Dr. Anbarasu Mohan Raj, MS, DNB, M.Ch (CTVS), FRCS (Glasg) Director and Clinical lead - Cardio Vascular and Thoracic Surgery

D.O.S: 28.12.2023

DIAGNOSIS:

TRIPLE VESSEL CORONARY ARTERY DISEASE CRITICAL LEFT MAIN DISEASE POSITIVE TMT CLASS II – III ANGINA NORMAL LV SYSTOLIC FUNCTION - EF: 60% TYPE II DIABETES MELLITUS

DYSLIPIDEMIA

SYSTEMIC HYPERTENSION

SURGERY:

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 3 GRAFTS: LIMA TO LAD, SVG TO OM, SVG TO PDA DONE ON 28.12.2023

BRIEF HISTORY:

Mr. Kaliyan.S, 71 years old male, a known case of Type II diabetes mellitus, Systemic hypertension, Dyslipidemia, Class II – III Angina, Positive TMT, CAD – Left main + Triple vessel disease, Normal LV systolic function, has come for CABG. Patient was apparently normal till 2 months ago when he developed jaw pain on exertion, which relieved at rest. Initially, he went to Krishna Hospital where he was advised TMT. He underwent TMT which showed positive for inducible ischemia. He was advised Coronary Angiogram. He underwent Coronary Angiogram on 18.12.2023 which showed Critical Left main disease + Triple vessel disease. He was referred from Krishna Hospital (Dr. Parthasarathy cardiologist) to Medway Heart Institute on 20.12.2023 and advised early CABG. Patient and attenders were explained about the nature of disease, risks and prognosis of CAD and the need for revascularization. Currently, he is getting admitted for the same. No H/O Breathlessness, Palpitations, Syncope or Swelling of Legs.

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

MedwayHospitals

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[@medway-hospitals

medwayhospitals



Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

Kodamhakkam 044-2473 4455

Mogappair

Chengalpattu

Villupuram

Kumbakonam 044-26530011 | 044-27426829 | 04146-242000 | 044-2473 4455 | 0884-2333367

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



UHID: MHI202381394



No H/O CKD, BA or Hypothyroidism.

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

TEMP

97.6° F

HR

60bpm

BP

130/70mmHg

SPO₂

98% in room air

CVS

S1S2 (+)

RS

BAE (+) Soft, BS (+)

Abdomen **CNS**

NFND

BLOOD INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	14.7	Male: 13.7 - 17.5	gms%
		Female: 11.2 - 15.7	
HAEMATOCRIT	43.8	39-52	%
TWBC	8860	4000 - 10000	Cells/Cumm
NEUTROPHILS	66.6	40-70	%
LYMPHOCYTES	26.0	20 - 40	%
EOSINOPHILS	1.6	0 - 6	%
MONOCYTES	5.4	0 - 6	%
BASOPHILS	0.4	0 - 2	%
PLATELET	252000	Male: 1.5 - 3.5	Cells/Cumm
		Female: 1.5 - 3.7	
Urea	40	14 - 40	mgs/dl
Creatinine	1.19	Male: 0.7 - 1.2	mgs/dl
		Female: 0.5 - 1.0	
		Child: 0.2 - 0.8	
Sodium (Na+)	142	135 - 145	mmol/l
Potassium (K+)	4.56	3.4 - 5.5	mmol/l
T. Bilirubin	0.18	0.2-1.0	mg/dl
D. Bilirubin	0.08	0.00 - 0.4	mg/dl
I. Bilirubin	0.10	0.4-0.6	mg/dl
S.G.O.T	14.0	<38	U/L
S.G.P.T	11.0	<41	U/L
ALP	66	Adult: 42 - 141	U/L
GGT	21.0	Male: 10 - 45	U/L
		Female : 5 - 32	
Total Protein	7.6	6.0 - 8.0	gm/dl
S. Albumin	4.4	3.5 - 5.0	gm/dl

	#9 1st Main Road, United India Colony	Kadambakkan Ohanni 600024 Ta	1.044 4040 0050
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Villupuram

f @MedwayHospitals

Mogappair

Kodambakkam

@medwayhospitals

Chengalpattu

@medway-hospitals

Kumbakonam

@medwayhospitals

Kakinada



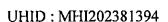
Medway Centre of Excellence (Chennai)

Medway Group of Hospitals

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

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







IPNO: IPHZ023002614 beat counts (A Unit of United Alliance Healthcare Pvt Ltd)

PROTHROMBIN TIME	12.5	Normal : 0.9 - 1.5 INR	
		Therapeutic Level	
		Myocardial Infarction : 2.0 -	
		3.0 Deep Vein Thrombosis:	
		2.0 - 3.0 Pulmonary	
INR	1.0	Embolism : 2.0 - 3.0	
		Artificial Cardiac Value: 3.0	
		-4.5 Recur.Systmic	
		Embolism: 3.0 - 4.5 INR	

HBA1C	6.5	Normal: Below 6.0 Good control: 6.1-7.0	%
		Fair Control: 7.1-8.0	;
		Unsatisfactory: 8.1-10.0	1
		Above 10 : poor control	
		(GHB is an index of your	
		blood	
		Sugar control for the past (3	
		months)	
T.S.H	3.96	Adult: 0.25 - 5.0 New born-	uIU/mI
		4days: 1.0-39.0 Child upto	
		14yrs: 1.0-9.0	
T3	111	"Adult : 60 - 152	ug/dl
1		New born - 4 days : 96 - 730	
		1 - 11 Months : 102 - 243	
<u> </u>	ı	1 - 9 yrs: 89 - 237	
T4	10.7	"Adult: 4.6 - 9.3	ug/dl
		New born - 4 days : 11.0 - 21.3	
		1 - 11 months: 5.8 - 16.1	
		1 - 9 yrs : 6.3 - 13.16	

ECG: HR - 74bpm, sinus rhythm, LVH (+).

ECHO: EF CALCULATED BY SIMPSON'S METHOD: LV EDV: 85ML, ESV: 36ML, EF: 58 %, ALL CHAMBERS NORMAL IN SIZED, NO REGIONAL WALL MOTION ABNORMALITY, NORMAL LV SYSTOLIC FUNCTION – EF: 60 %, NORMAL RV SYSTOLIC FUNCTION, RV TDI: 13CM/S, TAPSE: 21MM, AORTIC VALVE SCLEROSIS, OTHER VALVES STRUCTURALLY NORMAL, IAS / IVS INTACT, IVC NORMAL IN SIZE AND COLLAPSING, AORTIC GRADIENT - MAX GRADIENT - 6 MM HG, MEAN GRADIENT - 7 MM HG, TRIVIAL AR, NO AS, TRIVIAL MR, TRIVIAL TR, NO PAH, NO CLOT / VEGETATION / EFFUSION.

CAROTID DOPPLER: INCREASED INTIMA MEDIA THICKNESS, CALCIFIC PLAQUE NOTED IN BOTH CAROTID BULB EXTENDING TO LEFT ICA ORIGIN, NO FLOW LIMITING DISEASE. NORMAL BILATERAL VERTEBRAL DOPPLER STUDY.

Kumbakonam

CXR: PA film, lung fields clear

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		_	_	_		9		_			_		

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

MHI/HOSP/2022/118





United Alliance Healthcare Pvt Ltd)

COURSE IN THE HOSPITAL:

Mr. Kaliyan.S, 71 years old male, was admitted with above mentioned complaints. He underwent OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 3 GRAFTS: LIMA TO LAD, SVG TO OM, SVG TO PDA ON 28.12.2023. He was shifted to SICU with stable hemodynamics and nil supports. He was extubated on the next day (28/12/2023) at 16.50 pm. Drains were removed on POD1 (29/12/2023). He was shifted to ward on POD 2 (30/12/2023). Suture removal was done on POD5 (02/01/2024). Patient course in the hospital was uneventful. His medications are optimized and he is being discharged in a stable clinical status.

CONDITION ON DISCHARGE:

HR

84/min

BP

140/80mmHg

SPO₂

94% in room air

POST OP INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	12.1	Male: 13.7 - 17.5	gms%
		Female: 11.2 - 15.7	
HAEMATOCRIT	36.5	39-52	%
TWBC	8870	4000 - 10000	Cells/Cumm
NEUTROPHILS	72.4	40-70	%
LYMPHOCYTES	17.7	20 - 40	%
EOSINOPHILS	4.4	0 - 6	%
MONOCYTES	5.0	0 - 6	%
BASOPHILS	0.5	0 - 2 '	%
PLATELET	218000	Male: 1.5 - 3.5	Lakhs/cumm
		Female: 1.5 - 3.7	_
Urea	48	14 - 40	mgs/dl
Creatinine	1.19	Male: 0.7 - 1.2	mgs/dl
		Female: 0.5 - 1.0	
		Child: 0.2 - 0.8	
Sodium (Na+)	137	135 - 145	mmol/l
Potassium (K+)	3.75	3.4 - 5.5	mmol/l

ECG: HR – 84bpm, sinus rhythm, no fresh ST – T changes.

ECHO: S/P CABG, ALL CHAMBERS NORMAL IN SIZED, NO REGIONAL WALL MOTION ABNORMALITY, NORMAL LV SYSTOLIC FUNCTION, EF: 63%, NORMAL RV SYSTOLIC FUNCTION, AORTIC VALVE SCLEROSIS, OTHER VALVES STRUCTURALLY NORMAL, IAS/IVS INTACT, IVC NORMAL IN SIZE AND COLLAPSING, AORTIC GRADIENT - MAX GRADIENT -3MMHG, MEAN GRADIENT – 2MMHG, GRADE I DIASTOLIC DYSFUNCTION, AORTIC VALVES SCLEROSIS, TRIVIAL AR, NO AS, TRIVIAL MR, TRIVIAL TR, NO PAH, MILD LEFT, MINIMAL RIGHT PLEURAL EFFUSION, MINIMAL PERICARDIAL EFFUSION ANTERIOR TO RV, NO CLOT/ VEGETATION.

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UHID: MHI202381394



CXR: PA film, sternal wires seen, lung fields clear, minimal left, no right pleural effusion.

ADVICE MEDICATIONS:

SI NAME OF THE DRUGS		STRENGTH	DOSAGE	FRE	QUEN	CY	ROUT	RELATIONSHI	DURATION
NO.	WITH GENERIC NAME	SIKENGIN	DOSAGE	M	A	N	E	P WITH MEAL	DURATION
1	TAB. CLOPITAB A (CLOPIDOGREL + ASPIRIN)	1 TABLET	75MG / 75MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. FORTIUS (ROSUVASTATIN)	I TABLET	10MG	0	0	2	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. BETALOC (METOPROLOL)	1 TABLET	12.5MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB.LASILACTONE (FURSEMIDE + SPIRONOLACTONE)	1 TABLET	50MG/ 20MG	1/2	0	0	ORAL	AFTER FOOD	X 2WEEKS
5	TAB. MOSAPRIDE	1 TABLET	5 MG	1	0	1	ORAL	AFTER FOOD	X 1 WEEK
6	TAB.PARACIP (PARACETAMOL)	1 TABLET	500MG	1	0	1	ORAL	AFTER FOOD	SOS (IF PAIN OR FEVER)
7	SYP. CREMAFFIN PLUS (SODIUM PICOSULFATE+ LIQUID PARAFFIN + MILK OF MAGNESIA)	15ML		0	0	1	ORAL	AFTER FOOD	BED TIME (IF CONSTIPATI ON)
8	TAB. BEPLEX FORTE (ANTIOXIDANTS +MULTIVITAMINS+ MULTIMINERALS)	1 TABLET		I	0	0	ORAL	AFTER FOOD	I MONTH
9	SYP ALEX PLUS (DEXTROMETHORPHA N HYDROBROMIDE + GUAIFENESIN + PHENYLEPHRINE + CHLORPHENIRAMINE MALEATE)	10ML		0	0	1	ORAL	AFTER FOOD	BED TIME (1 WEEK)
10	TAB.ANXIT (ALPRAZOLAM)	1 TABLET	0.25MG	0	0	1	ORAL	AFTER FOOD	X 5 DAYS

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Kakinada Kumbakonam

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

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IPNO: IF**H2023 (1920)4 beat counts** (A Unit of United Alliance Healthcare Pvt Ltd)

DIABETIC MEDICATIONS:

Sl.	NAME OF THE DRUGS	STRENGTH	DOSAGE	FREQUENCY			ROUTE	RELATIONSHIP	DURATION
NO	WITH GENERIC NAME			M	A	N		WITH MEAL	
1	TAB. GLYCOMET GP2 (GLIMEPIRIDE + METFORMIN)	1 TABLET	2MG/ 500MG	1	0	0	ORAL	BEFORE FOOD	TO CONTINUE
2	TAB. ISTAMET (SITAGLIPTIN + METFORMIN)	1 TABLET	50/500 MG	0	1	0	ORAL	BEFORE FOOD	TO CONTINUE
3	TAB. GLYCOMET GP1 (GLIMEPIRIDE + METFORMIN)	1 TABLET	1 MG / 500MG	0	0	1	ORAL	BEFORE FOOD	TO CONTINUE

UHID: MHI202381394

DISCHA	DISCHARGE ADVICE			
DIET	HIGH PROTEIN, LOW SALT			
	LOW FAT AND DIABETIC DIET			
PHYSICAL ACTIVITIES	RESTRICTED.			
FLUID RESTRICTION	NIL			
	REVIEW WITH			
REVIEW	DR. ANBARASUMOHANRAJ AFTER			
ī	09/01/2024 WITH FBS, PPBS, HB, UREA,			
	CREATININE, SODIUM, POTASSIUM,			
	CHEST X RAY			

To report: If fever> 101 'F / Difficulty in breathing / Headache / Giddiness/chest pain/ Groin swelling/ bleeding / discharge at operated site/ Any other significant symptoms. In case of emergency Contact: Medway Hospitals @ 044 -43108959.

Typed by: Kalai

CONSULTANT SIGNATURE

Dr. Anbarasu Mohan Raj, MS, DNB, M.Ch (CTVS), FRCS (Glasg) Director and Clinical lead - Cardio Vascular and Thoracic Surgery

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Mr.KALIYAN S

71/Male/MHI202381394 27/12/2023/IPH2023002614

dt.anbarasu mohanraj



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INPATIENT INITIAL ASSESSMENT

Date: 21 12 V) Time of arrival in ward: 1:10 pm
Allergies (if Yes, specify details):
Drugs Yes Noy
Blood Transfusion
Food Yes No
Others
Vital Signs: Temp: 97-6 (°F) Pulse / HR: 60 (beats/min) BP: 130 / 30 (mmHg) Respiration: (breaths/min) SpO₂: 98 (%) Height: 162 (cms) Weight: 63 (kgs) BMI: 34 kg m²
Pain: Yes No. If Yes, Score: 70 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 Oficent was now admitted for CABG
No 4/0 Palpitations chest pair Discomfort
PAST MEDICAL HISTORY (with duration of illness); Diabetes Mellitus: ☐ Yes ☐ No. If Yes, duration: ☐ Hypertension: ☐ Yes ☐ No. If Yes, duration: ☐ Yes, durati
Others: - k/c/o CAD - LH -PTVD
Past Surgical History: B/L Certaract Surgery done at 2010 2022.

Pre	Present Medication (for Medication Reconciliation):					
S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
	TAB. TELMA	uong	Plo	1-0-0	Q3 12 13	☐Yes☐No
ର_	TAB- DOAGA TRIO	TRAN	olg e	(क)	29 12 13	□Yes□No
3_	CAP- ECOSPRIN AV	7604	Plo	001	23 12 12	☐ Yes ☑ No
η.	TAB- RUDININ	17ah	Plo	هما	27 12 23	
5_	TAB GORBITRATE	5mg	S/L	<u>حود</u>		☑ Yes ☐ No
٤.	TAB. GTN SORBITRAK	2.6	Plo	10-1	27/12/27	✓ Yes □ No
7.	TAB. HETZOK	1250	pto	100	27 12 2	Ves □ No
<u></u> မွှ.	TAB. 3 KAT	1 tats	Plo	100	27/12/20	Yes □ No
				_	, v	☐ Yes ☐ No
	•					☐ Yes ☐ No
Lif Sr Ot	Personal / Social-History (Tick whichever is applicable) Lifestyle: Sedentary Active Occupation: Smoking: Yes No Alcohol: Yes No Recreational Drug Use: Yes No Others:					
Pa	Menstrual and Obstetric History (to be filled up for female patients): General Physical Examination: Pallor: □ Yes □ No Icterus: □ Yes □ No Clubbing: □ Yes □ No Lymphadenopathy:					

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SYSTEMIC EXAMINATION
cỳs: *
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Respiratory System:
BAE (1)
Gastrointestinal System:
soft, Bs (t)
Central Nervous System:
PUFNO
Urinary / Reproductive / Locomotor System:
Skin / Opthalmic / ENT
(NI)
Suspected of contagious disease: Yes No Immuno compromised status: Yes No Isolation required: Yes No, if yes, Contact Airborne Droplet
Psychological Evaluation: Normal Anxious Depressed Others:
Nutritional Screening (ESPEN Guidelines for Nutritional Screening - NRS 2002);
Weight loss within the last 3 months? Yes No Is the patient severely ill? (e.g. in Intensive Therapy) Yes No
Reduced dietary intake in the last week? Yes No Is the BMI < 20.5? Yes No
Interpretation: Yes: If the answer is "YES" to any 2 questions, the patient is at nutritional risk No: If the answer is "NO" to all questions, the patient is at Normal and not at risk
Provisional Diagnosis: A: CAD - LH +TVD / 3dm / 9HTN Pyslipidenus
Plan of Care: Plan - CABG tomororo. Plo Preop ordeu.

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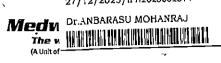
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Investigations Advised:						, ,	
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						. ,	
				Compression and an arranged and arranged and arranged and arranged arranged and arranged arra			
		•					
Diet Advice:			-				
☐ Nil per Oral ☐] Clear liquid diet [☐ Normal liqui	d diet	Diabetic I	iquid diet		
☐ Semisolid diet ☐	Soft solid diet [☐ South Indian	n normal diet	☐ North Ind	ian normal d	liet	
☐ Neutropenic liquid diet ☐	Others:			•.		_	
Early Discharge Planning (fill	in those which are a	ppropriate at thi	s stage):	PFE: Pa	tient Family l	Education	
Special support needed at ho	me	☐ Yes ☐ No	If Yes, PFE	∄ doņe			
Home equipment anticipated		☐ Yes ☐ No	If Yes, PFE done and equipment advised				
Physiotherapy at home anticip	pated	☐ Yes ☐ No	es No If Yes, educated on physical limitations, if any				
Wound care needs anticipated	d at home	☐ Yes ☐ No	If Yes, edu	ucated on signs	on infection		
Pain Management		☐ Yes ☐ No	If Yes, PFE	E done and med	lication advis	sed	
Special Dietary needs		☐ Yes ☐ No	If Yes, educated on dietary restrictions, food drug interactions and allergies				
Continuous / ongoing care an	nticipated	□ Yes □ No	If Yes, educated on various aspects of ongoing care required				
Other special education need,	, i.e.:	☐ Yes ☐ No	☐ Yes ☐ No ☐ If Yes, PFE done				
Nature of post hospital needs infection control, fall risk, etc.		☐ Yes ☑ No	☐ Yes ☐ No If Yes, specific education given				
Others:		, -	•				
Signate	ure	Name		Reg. No.	Date	Time	
Resident Doctor	.V. Jayanthi	DR-5-7	HTTN A YO	170318	- ` ` 	13:25 pm	
Consultant		DR. Ans	ARASU	55476	271/2122	5 14 200	
Patient Attendant C	Smud . 1	Relationship	Smaller	H	9-1 12/22	12,25,	

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Mr.KALIYAN S

71/Male/MHI202381394 27/12/2023/IPH2023002614









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	DOCTOR'S PROGRESS NOTES
DATE	NOTES
27/12/28	(1.18 - 10r 18 Elargo (DNO)
4200pm)	CAG-done CTVI)
	Planfor CARG (28 (12/28)
	0/E: Consurous, oviented, appointe
	28 (E: UPI: C152(A)
	RS: RAEGO
	17/m: 20/2.
	Adria:
	- Vitals monitoris
	- 70 do - pre-op Te
	- Part preparition
	- NPO prom 12:00 aug - 120 le/2 - 120 le/2

DATE	NOTES
DATE	NOTES
	SIB Do mohamed Hydron
27/12/23	
	Δ'CAP-TVD/T2DM/HTN) Pyslipidemina
10km	Pys light de mija
	Plan: CABG JGA
	Pahint Communication
	Papint Consus.
	Afébrile.
	nje prite.
	State P/A-> EST. NI
	No BARR
	Stable No BACO
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	- Monidos Walls
	chard
	Neo James 12 Aug
-	Con as to
	- NPO from 12Bm, Consent - Parts & Preparator
	This of preparation
	- Como
	(160M)
1	







Mr.KALIYAN S 71/Male/MHI202381394 27/12/2023/IPH2023002614

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DT.ANBARASU MOHANRAJ

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	DOCTOR'S PROGRESS NOTES
DATE	NOTES
28/12/2023	Mr. Kaliyan Tiylm underwent openax agrapts
@ 12:45	and he was shifted to sicu & following homodymenics the 58 ppm Bp-170/70 mmHg cxp-11 mmHg Spo 100 x on ventilating ventilator:
	Modo: SIMV + PS Plag: 50x poop:5 mm Hg. Supports: plan: plan: plan: plans & Pontubate bloon pt fully a wake
	Por 11236 Do. pobanase feel pa. Kantaika MH026
-	
	

DATE	NOTES
29/12/2023	SB: Dr. Anharia su l'Dr. Rajesti l. Dr. Praveon
@\$.55	
	SIP: OPLAB X 3 grafts.
POD#1	patient comfortable
13.0	ol El conscious, oriental. Afebrile
u – 38	·Bp - 126/44 panty
Lr - 1.16	HR- TH BPM
Na-132	· 5 po 94 % or man au
K-4.53	· Plo _ 2302 / 2430 m L / Bal(+128 m)
	· on weath
RBS - 190 mg	1dL Adequate wiene ocetput
	- Tolemating feeds
ABY	peripheriee warmt
	Supports: NIC
•	Potal detain: 360ml
po <u>, - 69</u>	Plan
tlloz - 25-2	. RF-2.4 clitros/dage
BE - 0.9	: Consider chest physic
	. Remove drains gartery le
, 	mobilize @10 Am
	· rebulization
	· spinomedny
· .	T. METO PROLOL 12.5mg 1-0-1
	· T. GLY COMET GP 0.5 1-0-1 (BF)
	· Shift to In IT
 -	Opple .
	- \·



Mr.KALIYAN S 71/Malc/MHI202381394

27/12/2023/IPH2023002614







DOCTOR'S PROGRESS NOTES

DOCTOR 3 PROGRESS NOTES			
DATE	NOTES		
30/12/2028	S/B Dr. Anbrasas Dr. Rajosh / Dr. Proveen		
8.00			
	S/P OPCABO × 2 grofti POD-2		
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Cr. 1.23			
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DATE	NOTES
30/12/23	
	S1B-Dr. Svi Elargo (DMO)
1:45pm	
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0002 (°	2(E)
EF-61%	CAS SISS
	P/A: 1345 @
	(10): 200-2
	Ador.
	- PF 2-41/2 /day
	- PF 2-415 Iday - Church physis + sprometry
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	- Vitule no nitori
	-Flo-Charles
	Flor
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Mr.KALIYAN S

71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj





MHI/IP/2022/041

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•	
	DOCTOR'S PROGRESS NOTES
DATE	NOTES
80.12.23	5/B DX Anuscusa
·	
P.30M	Spopenby 3grouts
	Patient revieuled.
ppp-2	do' generalised tirednes
	OB Patient Convious, oriented, A Febrile
	7
011/420	RS - BAE (P)
. R-2-4/1/100	CNS - NENID
tatol	e LIE. Doesing intact
vitallo stabl	no shakage
	Adria
,	- monetor vitals
	- confinue the dauge as per
•	chart.
, •	- WP Feverspikes desaturation dehid
	- Dlan' C.R no 1.07.24
lo	- mobilise the patient - confinue thest Physip & spixometry.
K, O)	- Confinue Chest Physip & spixometry.
BUN	

DATE	NOTES
	S/B Dr. Molumed lydrom.
-122	
30/12/	
// 00	Post op case of OPCAR & Sgrafts
John	
	PoD-2
	Pahent Commen
	Patent Connus onunted. Ofebrule
	Alekule.
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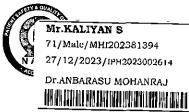
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`	(A Unit of United Alliance F	feathcare Pvt Ltd)		
		DOCTOR'S PROGRESS NOTES		
	DATE	NOTES		
	34 12 23	- 5 B DX · Anwyg		
_	1000AM)	patient reviewed		
	1000	clo pain in the dusqualsite.		
	600-3	DE PATIENT CONSULACIS, CONCINTRAL,		
	1979	98: parent with the constitution of the consti		
•	7	RI - RAFA).		
	C. P. JOHN	CNR - NENID		
		P/n- ontt, non-fendles		
		Als' Doesing Contact		
	Vi-talls Stable	nosoakage		
Advice				
	- monitos vitals			
		- Confinue the days as Per		
	. 60	chart.		
	V March	- mobilise the patient		
}	(13497)	- continue the chest Physical spisometry		
	01/10/02	Al To Mahamur		
•	31 112 23	5/B Do Anbarasu		
	11-80 Am	Patient reviewed		
ŀ	71 00-	clo 'Sleeping disturbances & cough		
	Advice			
ļ		/ - monitor vitals		
	- MM ->	- continue the dauge as perchapt		
	(2000)	- 7 Anxit 025mg HS		

	<u> </u>
DATE	NOTES
	S/8 Dr. Mdunied hydron
	-
21/2/23	
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	PoD-3
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	Onented
	Padent Consins Onented Yebrile
	(P.28 c2w
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	winds no spet of .
	DEW
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	- To sollow on p
	Change .
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	- Mobilise Kie Padient - Tomorom To do
	Don as 1 Do do
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	(1607) PANOP (1607) MUOND ECH, ECHO,
	ECh, Rema,
	EXR POLL
	
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Institute

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DOCTOR'S PROGRESS NOTES						
DATE NOTES						
0/0/24	SB Dr. Anusuug					
MAM	SIPOPEAB.					
	patient sellelled					
000 A	clo' mild pain in the suggical site -					
עטץ						
	- Advice					
Vitalistab	e continue tre same					
MIMA						
	plan SR tomosous					
W.M.						
1345	9). S/S Dr. Moliamed Hydron.					
()						
11/29	Post- of case of opeABX 3grafts					
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	Stable Non RAFED Plans 80/4 NT					
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	Plan 1 Dlo do m					
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	ECG, ECGo, CKRPome					





Mr.KALIYAN S 71/Male/MHI202381394 27/12/2023/IPH2023002614 Dr.ANBARASU MOHANRAJ



rt beat counts

MEDWAY HOSPITALS CARDIAC SURGICAL CHECK LIST

Name	Me.	Kaliya	n
------	-----	--------	---

Age 71 ylmale UHID MH 162381394

Diagnosis CAD-LIM+TYD, (M) LV function Plan EF-60%, TOPM, HTN

Serology NON- rective

EURO Score / STS Score 1. ススソー

T. Udapa Trio, T. Telmisarta, T. Buspinin PRE OP DRUGS (ACE/ARB/ANTIPLATELETS): Stopped on 23/12/2023

Diabetes Mellitus (HB1AC) も、5 メ

Associated Illness

Carotid Doppler NO flow lemiting obsease

Sr. Creatinine 1.19 mg/oll P9/2118 - 12.5/1.0mm

Allen's Test

Thyroid Enzymes $T_3 - W$

TSH - 3.96

Tu - 10.7

Any other illness of concern

Myocardial viability if needed

Varicose Veins

Pulmonologist Clearance

Nephro Clearance:

Neurology Clearance:

Dental Clearance:

Mitral Regurgitation Assessment : Trivial MR / NO PAH (RSVP 1 Hommity)

Nursing:

Billing Clearance:

Physiotherapy

Spirometry taught : + aught

Concerns from Surgical Team :

SIGNATURE:

PA. Koutlika (MH10216)

there he was advised to do TMT and showed positive.

Then he was advised to do TMT and showed positive.

Then he was advised CAY. He underwent CAY on (

Which showed CAD - IM + Triple vessel disease. He was reffered to Med way Heart unstitute from knishna hospital

(Dr. parthasarathy (cardiologist)). He came to MH; on 20.12.2023. Where he was advised CAY.

NO HIO Breatheless ness, chest pain, CVA, Seizum, BA



CHENNAI: # 2/26, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel: 044 - 2473 4455 [Mobile No: 9962 985 985

KUMBAKONAM: No. 142-B, Sri Balasubramaniyan Nagar, Pilliyam Pettai, Ammachathiram (Post), Thiruvidaimarudhur (Taluk), Kumbakonam - 61 2103. (Taniore Dist). Ph: 0435 - 2412345 | Mob : 7397720491 E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com

PRE-OPERATIVE CHECKLIST Mr.KALIYAN S

Name	71/Male/MHI202381394 27/12/2023/@H2023002614	No.: 205	1981391
Ward	Dr.Anbarasu mohanraj Bed No.: 10.5- B	B.S.	A.S.
	Clinical Diagnosis:		-
	CAID - LM TVID	<u> </u>	<u> </u>
	Proposed Procedure:	_	
	CARG		
	CHECKLIST		
1.	Identification Band on Hand Checked ?	<u> </u>	/
2.	Surgical consent Signed? a. Special Consent signed if required.		
3.	Anesthetist Consultation (If required?)		
4.	History AND Physical Onchart?		
	a. Height	V	
5.	Allergic to drugs?		
6.	Surgical Preparation done?		
7.	Nill by Mouth From		
8.	Blood Grouping & Rh Typing .D		
9.	Investigation		
	X-Ray DECG DIAB		-
10.	Blood Sugar 113 mg ld Time 6.3	-	<u> </u>
11.	TPR Chart Pulse 85 blm Temp 976 BP 110 62 RR 20		
12.	Time Voided		7
,	a. Retention Yes No		
13.	Enema ☐ Yes ☑ No		

14.	a. Prosthesis Removed		
15.	Valuables and Jewellery Removed ☐ Yes ☐ No Secured ☐ Yes ☐ No	/	/
· 16.`	a. Time 5.00 b. Nurse		
17.	Blood Transfusion requisition Onchart		/_
18.	X-Ray 1 CAG Report > 10 CAROLIO DOPPLEY PU	Dort	
	ECG/ECHO 1, Screening Follo Paport->0	(G)	
	Ultra Sound		
	C.T. Scan		
	MRI Scan		_
	TMT		
	Medication		
	7.7 12 23		
	T. PAN LIOMS 7 GIVEN AT .		
	T. AJPRAX O.SIMG 21:00 Polito	V	
	28 12 2-3		
			£
3	Others DEPEX D. GIVEN AT 5.00 - 120.	~	

Nurse Signature







Mr.KALIYAN S
71/Male/MHI202381394
27/12/2023/IPH2023002614
Dr.ANBARASU MOHANRAJ

need arises.

CONSENT FOR SURGERY

1. N	Mr./Ms./Mrs Mcu Kallyan The Patient or Representative of patient have (Please
	correct option and below):
[·	Read
	I/We have been explained the current clinical condition of me/my patient
	Been explained this consent form in English, which I fully understand and understood the information
	provided about the disease . Carowary ARTERY DISEASE / TRIPLE . NESSEL DISEASE and about the
	procedure
•	I am now aware of the intended benefits, possible risks and complications and available alternatives to the said operation / procedure. I am also aware that results of any operation / procedure can vary from patient to patient and I declare that no guarantees have been made to me regarding success of this operation / procedure. I am aware that while majority of patients have an uneventful operation and recovery few cases may be associated with complications. I am aware of the common risks and complications associated with this operation / procedures and understand that it is not possible to list all possible risks and complications of any operation / procedure.
•	I have been told about additional procedure that may be come necessary during the surgery which includes
•	I also understand that sometimes a planned operation / procedure may need to be postponed or cancelled if patient's clinical condition worsens or due to any unforeseen technical reason. I am also aware that I can withdraw my consent at any point of time at my own risk and consequence by submitting the withdrawal in writing.
•	I am aware that I may require administration of blood and / or blood products during or after the operation / procedure as found necessary by the doctor (for which a separate consent shall be obtained).
	I am now also aware that during the course of this operation /procedure the doctor will be assisted by medical

• I am also aware of the expected course after the operation / procedure and the care to be provided and understand that sometimes admission to an Intensive Care Unit and or extension of duration of hospitalization may be required and or there may be requirement of extra medicines or treatments thereby leading to increase in the treatment expenses depending upon the body's response to the treatment / procedure.

and paramedical team and that the doctor may seek consultation / assistance from relevant specialists if the

Possible risks & complications 1. Bleeding 2. Intertin 3- Shoke	4 Any thouse
5. Prolonged Icu stay 6. Mild mik to life	
- Benefits Symptom for Survival	
* Alternatives 13igh suik PTCA	
• The likelihood of success of the surgery (Percentage / Other commands) 967.	
• Possible results of non-treatment 1. Hypocoulic Infantion	

2. Heart Fadur,

I declare that I have received and fully understand the information provided in this consent form, that I have been given an opportunity to ask questions relating to my ailment, the operation / procedure being performed, its risks, consequences, alternatives, potential complications and intended benefits and recovery and that all my questions have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my sign this form.

DETAILS	PATIENT / RELATIVES	WITNESS	
Name (in BLOCK LETTER)	T. S. bly	K-SARANANAN	
Relationship	Self.	SON	
Signature	Todaly.	K. Soranou	
Date & Time	27/2/23 @ 14.00	27/12/23 @ 14:00	
Name & Signature of Doctor with Registration No.:			
	112236	112 236.	

Dr. Anbarası Mohanra: Reg No: 55476

Doctor Seal





இந்த ஒப்புதல் படிவம் ஆங்கிலத்தீல் விளக்கப்பட்டுள்ளது. இந்த ஒப்புதல் படிவத்தில் கொடுக்கப்பட்ட சிகீச்சையின் செயல்பாட்டின் முழுப்பெயர்

எனது / என் நோயாளியின் தற்போதைய மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளேன்.



1	நோயாளி விவரங்க	a:(Affix Label here)
į	សបរបាច់ :	
į	UHID :	
i	i I Beir Ceff	unedenh .

தோவு செய்யவும்

படியுங்கள்

அறுவை சிகீச்சை ஒப்புதல் படிவம்

) ச ய	ுல்முறை பற்றிய தகவல்களை நான் முழுமையாகப் புரிந்து கொண்டேன்.
•	நோக்கம் கொண்ட நன்மைகள், சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்களைப் பற்றி நான் இப்போது அறிவேன். மேலும் அந்த
	செயல்பாடு / நடைமுறைக்கு மாற்றுகளை கீடைக்கச் செய்கீறேன். எந்தவொரு செயல்பாட்டின் / நடைமுறையின் முடிவுகளும்
	நோயாளியிலிருந்து நோயாளிக்கு மாறுபடும் என்பதையும் நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையின் வெற்றி குறித்து எந்த
	உத்தரவாதமும் எனக்கு செய்யப்படவில்லை என்று நான் அறிவிக்கீறேன். பெரும்பாலான நோயாளிகளுக்கு சீரற்ற செயல்பாடு மற்றும்
	மீட்பு இருக்கும்போது சில வழக்குகள் சிக்கல்களுடன் தொடர்பு படுத்தப்படலாம் என்பதை நான் அறிவேன். இந்த செயல்பாடு /
	நடைமுறையுடன் தொடா்புடைய பொதுவான அபாயங்கள் மற்றும் சிக்கல்களை நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையுடன்
	சாக்கியமான அனைக்கு அபாயக்களையும் சிக்கள்களையும் புடியாவிட முறுயாகு என்பதை பரிக்கு கொள்கிறேன்

- நோயாளியின் மருத்துவ நிலை மோசமாக இருந்தால் அல்லது எதிர்பாராத எந்தவொரு தொழில்நுப்ப காரணத்தினாலும் சில
 நேரங்களில் தீப்பமிப்பட்ட செயல்பாடு / நடைமுறைகளை ஒத்திவைக்க அல்லது ரத்து செய்ய வேண்டும் என்பதையும் நான் புரிந்து
 கொள்கிறேன். எனது சொந்த ஆபத்து மற்றும் விளைவுகளில் எந்த நேரத்திலும் எனது ஒப்புதலை நான் திரும்பப் பெறுதலை
 எமுத்துப்பூர்வமாக சமர்ப்பிக்குவதன் மூலம் திரும்பப் பெற முடியும்
- மருத்துவரால் தேவையான செயல்பாடு / நடைமுறையின் போது அல்லது அதற்குப் பிறகு இரத்த மற்றும் / அல்லது இரத்த தயாரிப்புகளை எனக்கு நீர்வாகம் தேவைப்படலாம் என்பதை நான் அறிவேன் ஒரு தனி ஒப்புதல் பெறப்பட வேண்டும்).
- இந்த அறுவை சிகீச்சை / நடைமுறையின் போது மருத்துவர் மற்றும் துணை மருத்துவக் குழுவால் உதவப்படுவார் என்பதையும், தேவை
 ஏற்பட்டால் தொடர்புடைய நிபுணர்களிடமிருந்து மருத்துவர் ஆலோசனை / உதவியை நாடுலாம் என்பதையும் நான் இப்போது
 அறிவேன்.

் சாத்தியமான அபாயங்கள் மற்றும் ச	Aக்கல்கள்	
-		
நன்மைகள்		·
மாற்றுவழிகள்		
அறுவை சிகிச்சையின் வெற்றி வாய	ப்ப்பு (சதவீதம் / பிற கட்டளைகள்)	
சிகீச்சையின்றி சாத்தியமான முடிவு	கள்	
•	ு அலகு மற்றும் / அல்லது மருத்துவமனையில் ம கள் அல்லது சிகீச்சைகளின் தேவை இருக்கலாம். இ	
• •	நடத்தும் நோக்கத்திற்காக மற்றும் பொருத்தமான மு	
	தியை அகற்ற மருத்துவமனையை நான் அங்கீகரி. றும் முழுமையாகப் புரிந்து கொண்டேன் என்று	
	றும் குழுமையாகப் புளந்து என்ணடைன் என்று நளக் கேட்க எனக்கு வாய்ப்பு வழங்கப்பட்டது. அத	
	றும் மீட்பு மற்றும் எனது கேள்விகள் அனைத்தும்	· -
கையெழுத்திடும் நேரத்தில் என் முன் நிரப்பப்பட்டன என்று நான் மேலும் ச	ள்னிலையில் செருகல் மற்றும் நிறைவு செய்ய வே அறிவிக்கீறேன்.	ண்டிய அனைத்து துறைகளும் இந்த வடிவத்தி
விபரங்கள்	நோயாளி / உறவினர்	சாட்சியம்
பெயர்		,
உறவுமுறை		
கையொப்பம்		
நாள் & நேரம்		
மருத்துவரின் பெயர் மற்றும் பதி	ഖ്ര எண், கையொப்பம்:	



Mr.KALIYAN S
71/Malc/MHI202381394
27/12/2023/IPH2023002614
C
Dr.ANBARASU MOHANRAJ
C



CONSENT FOR ANAESTHESIA SERVICES

1. KALIYAN	JaB.	the patient or Sthe representative of patient have,								
(please tick the correct option ab										
☐ flead ☐ f/We have been explained the current clinical condition of me / my patient										
		h, which I fully understand and understood the information provided about								
Operation/Procedure		BYPASS BRAFTING								
 -	1.001.00.10.1.1.7									
(full name of operation / procedul	re given below in this	consent form)								
expected outcome and what needed for this operation, so the sen explained to me to with anaesthesia can occur sensation, loss of limb function. I understand that these risks they may apply to a specificity for my procedure and that the physical condition, the type of the lithas been explained to me without sedation, may not send anaesthesia. It has been may be needed to control venous catheter.	could happen if my of that my doctor can perhat all forms of anae and include the rerent, paralysis, stroke, to apply to all forms of a type of anaesthesia. It is an eanaesthetic technif procedure, my doctor that sometimes an succeed completely explained to me that	edure and has advised me of alternative treatments and told me about the condition remains untreated. I also understand that anaesthesia services are enform the operation or procedure. It is sthesia involve some risks. Although rare, unexpected severe complications note possibility of infection, bleeding, drug reactions, blood clots, loss of brain damage, heart attack or death. In aesthesia and that additional or specific risks have been identified below, as understand that the type(s) of anaesthesia service checked below will be used ique to be used is determined by many factors including my / my relative's or's preferences, as well as my own desire. In anaesthetic technique which involves the use of local anaesthesia, with or and therefore another technique may have to be used including general the following may be needed as part of anaesthesia during or after surgery Lumbar Puncture Tracheostomy transfusion I lou Admission / Recovery Others								
General Anaësthesia	Expected Results	Total unconscious state that may involve placement of a tube into the windpipe to maintain airway								
Alternatives '	Technique	Drug injected into the blood stream, breathed into the lungs, or given by other routes								
☐ Spinal ☐ Epidural	Risks	Sore throat, injury to vocal cords, teeth, lips, eyes; awareness during the procedure, memory dysfunction / memory loss, aspiration pneumonia, permanent organ damage, brain damage								
☐ Others	Benefits	- Early Recovery								
<u> </u>	Deficition , ,	- Relief of Anxiety								
☐ Spinal or Epidural Analgesia / Anaesthesia	Expected Results	Temporary decreased or loss of feeling and / or movement in the lower half of the body								
 ✓ With Sedation /GA ✓ Without Sedation Alternatives 	Technique	Drug injected through a needle / catheter placed either directly into the spinal canal or immediately outside the spinal canal								
☐ GA ☐ Others	Risks	Nerve damage, persistent back pain, headache, infection, convulsions, bleeding / hematoma, toxicity due to local anaesthetic, chronic pain, medical necessity to convert to general anaesthesia, brain damage								
	Benefits	Post-operative pain relief with epidural catheter that can be left in-situ safer under certain conditions								
Major / Minor Nerve Block	Expected Results	Temporary loss of feeling and / or movement of a specific limb or area								
☐ With Sedation /GA ☐ Without Sedation	Technique	Drug injected near nerves providing loss of sensation to the area of the operation								
Alternatives ☐ GA	Risks	Nerve damage, persistent pain, infection, bleeding / hematoma, toxicity due to local anaesthetic, medical necessity to convert to general anaesthesia, brain damage								
 IV Regional Anaesthesia Spinal/Epidural Anesathesia Others 	Benefits	- Pain Free - Safer under certain conditions								

						<u> </u>		
☐ Intravenous R	egional Anaesthesia	Expected Results	Temporary loss of feeling and / c	r movement of a limb	•			
☐ With Sedat		Technique	Drug injected into veins of arm o					
Alternatives	or Nerve Block	Risks	Infection, convulsions, persistent numbness residual pain, injury to blood vess					
☐ Major/Mine	OF Merve block	Benefits	- Pain Free					
☐ Others		Dellento	-Safer under certain conditions					
	aesthesia care	Expected Results	Decreased anxiety and light sed	ation similar to norma	al sleep			
(with sedation) Alternatives		Technique	Drug injected into vein of arm					
General and		Risks	Prolonged sedation, need for air	way control				
☐ Spinal / Epi☐ Others	ourai 	Benefits	Anxiety free; Early discharge					
	aesthesia Care	Expected Results	No changes in the system					
(without sedati Alternatives	on)	Technique	None					
☐ General and		Risks	Patient may have pain and anxie	ty				
☐ Mild Sedatio ☐ Others	on	Benefits	Early discharge					
carrying out t risks and con I, the above n	he said operation / pr nplications, intended named Patient / name	ocedure on mysel benefits and possible od patient's representa	nat I have been made aware of if or my above named paties alternatives. ative, do further hereby declar consent without any fear, thre	ent being fully awar re that I am about 1	e of the nature, po	tential		
	Signature /	Thumb Impression*	Name		Date	Time		
Patient	1.3	و مراحان	T.S-K.	+CIYAN	97 1222	111 14.		
Surrogate/Guar	dian	Momos -	Write name and relations	2-4 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1-	<u> </u>			
(ii applicable #)			- 	snip with patient)	12 4 12 12 3.	1110		
Reason for surrogate cons		able to give consen	n because:					
Witness	<u> </u>		A. Nardhini		07/12/23	14110		
Interpreter (if applicable)								
I, the unders	ourse, and possible a	explained the nature, alternatives to the pla	tient is a minor or unable to give , potential risks and complic nned operation / procedure, ully as described in this docur	ations, intended b to the patient / pati	penefits, expected ient representative	i post- e. l am		
	Signature	Name		Reg. No.	Date	Time		
Consent obtained by	Josephy	A 14	1, S. Sylvester	43570	27/12/28	14,10		
	+ 0							



நோயாளி விறைங்கள் : (Affix Label here)								
សោយក៍ ;								
UHID:								
பிறந்த தேதி:	பாலினம்;							
சேர்க்கை தேதி:								
மாக்கவர்:								



<u>மயக்க மருந்து சேவைகளுக்கான ஒப்புதல்</u>

1 நோயாளி மேலேயும் கீழேயும் சரியான விருப்ப <u>ச்</u>	- -										
என்னை / என் நோயாளியின் தற்போதைய மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளோம். ஆங்கிலத்தில் இந்த ஒப்புதல் படிவம்											
	விளக்கப்பட்டுள்ளது. இது வழங்கப்பட்ட தகவல்களை நான் முழுமையாக புரிந்துகொண்டேன்.										
செயல்பாடு/செயல்முறை		Good Time Time Time Total of Total									
											
இந்த ஒப்புதல் படிவத்தீன் கீழே கொடு	க்கப்பட்ட செயல் பாட்டு ந	டைமுறையின் முழு பெயரி									
எதிர்பார்க்கப்பட்ட முடிவைப் பற்றி எ	என்னிடம் கூறினார். என	ங்களை விளக்கியுள்ளார் மற்றும் மாற்று சிகிச்சைகளுக்கு எனக்கு அறிவுறுத்தியுள்ளார் மற்றும் எது நிலை சிகிச்சையளிக்கப்படாவிட்டால் என்ன நடக்கும், இந்த செயல்பாட்டிற்கு மயக்க மருந்து எ. இதனால் எனது மருத்துவர் அறுவை சிகிச்சை அல்லது செயல்முறையைச் செய்ய முடியும்.									
கடுமையான சிக்கல்கள் ஏற்படல	் அனைத்து வகையான மயக்க மருந்துகளும் சில அபாயங்களை உள்ளடக்கியதாக எனக்கு விளக்கப்பட்டுள்ளது. மயக்க மருந்துகளுடன் எதிர்பாராத கடுமையான சிக்கல்கள் ஏற்படலாம். தொற்று நோய், இரத்தப்போக்கு, போதைப்பொருள் எதிர்வினைகள், இரத்த உறைதல், உணர்வு இழப்பு, மூட்டு செயல்பாடு, பக்கவாதம், மூளை பாதீப்பு அல்லது மரணம் போன்ற தொலைதூர சாத்தியங்களை உள்ளடக்கியிருக்கலாம்.										
அடையாளம் காணப்பட்டுள்ளன விண்ணப்பிக்கலாம். கீழே சரிபார்க்	இந்த அபாயங்களை அனைத்து வகையான மயக்க மருந்துகளுக்கும் பொருந்தும் என்பதையும் கூடுதல் அல்லது குறிப்பிட்ட அபாயங்கள் கீழே அடையாளம் காணப்பட்டுள்ளன என்பதையும் நான் புரிந்து கொள்கீறேன். ஏனெனில் அவை ஒரு குறிப்பிட்ட வகை மயக்க மருந்துக்கு விண்ணப்பிக்கலாம். கீழே சரிபார்க்கப்பட்ட மயக்க மருந்து சேவையின் வகை (கள்) எனது நடைமுறைக்கு பயன்படுத்தப்படும். மயக்க மருந்து நுட்பம் எனது உறவினர் உடல்நிலை, எனது மருத்துவரின் விருப்பங்கள் மற்றும் எனது சொந்த விருப்பம் உள்ளிட்ட பல காரணிகளால் தீர்மானிக்கப்படுகிறது என்பதை நான் புரிந்து கொள்கீறேன்.										
		படுத்துவதை உள்ளடக்கிய ஒரு மயக்க மருந்து தொழில் நுட்பத்தை, மயக்க மருந்து இல்லாமல் நந்து உட்பட பயன்படுத்த வேண்டியிருக்கும் என்று எனக்கு விளக்கப்பட்டுள்ளது. 									
ြ பொது மயக்க மருந்து	முழ்வுகள் எதிர்பார்க்கப்படும்	காற்றுப்பாதையை பராமரிக்க ஒரு குழாயை காற்றாலையில் அமர்த்துவதை உள்ளடக்கிய மொத்த மயக்க நிலை									
மாற்று மருந்து	நுட்பம்	இரத்த ஓட்டத்தில் செலுத்தப்படும் மருந்து, நுரையீரலில் சுவாசித்து அல்லது பிற வழிகள் வழங்கப்படுகின்றன									
முதுகெலும்பு இவ்விடைவெளி	அபாயங்கள்	தொண்டைப்புண், குரல் வடங்கள், பற்கள், உதடுகள், கண்கள், செயல்முறை, நினைவக செயலிழப்பு, நினைவக இழப்பு, அயிலாஷைகள், நிரந்தர உறுப்பு சேதம், மூளை சேதம் ஆகீயவற்றின் போது விழிப்புணர்வு									
மற்றவை	நன்மைகள்	– ஆரம்ப மீட்பு – பதட்டத்தீன் நிவாரணம்									
முதுகெலும்பு அல்லது இவ்விடைவெளி / மயக்க மருந்து	 எதிர்பார்க்கப்படும் முடிவுகள்	உடலின் கீழ்பாதீயில் உணர்வு அல்லது இயக்கத்தின் தற்காலிக குறைவு அல்லது இழப்பு									
மயக்க மருந்து / பொது மயக்க மருந்து	நுட்பம்	ஊசி / வடிகுழாய் வழியாக செலுத்தப்டும் மருந்து நேரடியாக முதுகெலும்பில் அல்லது உடனடியாக முதுகெலும்பு கால்வாயுக்கு வெளியே வைக்கப்படுகிறது.									
் பயக்க மருந்து இல்லாமல் பாற்று மருந்து ் பொது மயக்க மருந்து	அபாயங்கள்	எலும்பு சேதம், தொடர்ச்சியான முதுகுவலி, தலைவலி, தொற்று, இரத்தப்போக்கு, இரத்தம்போதல், ஹெமடோமா, உள்ளூர் மயக்க மருந்து, நாள்பட்ட வலி, மயக்க மருந்து, மூளை சேதத்திற்கு மாற்று மருத்துவ சேவை காரணமாக நச்சுத்தன்மை									
மற்றவை	நன்மைகள்	சில நிபந்தனைகளின் கீழ் சிட்யூவில் பாதுகாப்பாக விடக்கூடிய எபிட்ரி வடிகுழாய்களுடன் செயல்பட்டு வலி நிவாரணம்									
பெரிய / சிறிய நரம்புத் தொகுதி] மயக்க மருந்துடன் / பொது மயக்க மருந்து	எதிர்பார்க்கப்படும் முழுவுகள்	உணர்வு மற்றும் ஒரு குறிப்பிட்ட மூட்டு அல்லது பகுதியின் தற்காலிக இழப்பு									
] மயக்க மருந்து இல்லாமல் சாற்று - மருந்து	நுட்பம்	செயல்பாட்டின் பகுதிக்கு உணர்வு இழப்பை வழங்கும் நரம்புகளுக்கு அருகில் மருந்து செலுத்தப்படுகிறது									
] பொது மயக்க மருந்து] IV பிராந்தீய மயக்கமருந்து	அ பாயங்கள் 	எலும்பு சேதம், தொடர்ச்சியான வலி, தொற்று, இரத்தப்போக்கு, ஹெமடோமா, உள்ளூர் மயக்க மருந்து,மருத்துவ சேவை காரணமாக நச்சுத்தன்மை, மயக்க மருந்து, மூனை சேதத்திற்கு மாறுதல்									
] மூதுகெலும்பு / இவ்விடைவெளி மயக்கமருந்து] மற்றவை	நன்மைகள்	– வலி இலவசம் – சில நிபந்தனைகளின் கீழ் பாதுகாப்பானவை									

நரம்பு மண்டலம் மயக்க மருந்து ப மயக்க மருந்து		எதிர்பார்க்கப்ப முடிவுகள்	1 22 6000	ார்வு மற்றும் ஒரு குறிப்பிட்ட மூட்டு	இயக்கத்தீன் தற்காலி	க இழப்பு				
மயக்க மருந்து இல்லாமல் மாற்றுகள்		நிட்பம்	_	நீர்னிக்கேயைப் பயன்படுத்தும் பே	ாது கை அல்லது கை	நூம்புகளில் செலுத்	தப்படுகிறது தப்படுகிறது			
🗌 பெரிய / சிறிய நரம்பு தொகுதி		அபாயங்கள்	ர தொற்	று, வலிப்பு, தொடர்ச்சியான உண	ர்வின்மை, மீதமுள்ள (வ ி, இரத்த காயங்க	 எளுக்கு காயம்			
🔲 பொதுவான	நன்மைகள்		– ഖരി இலவசம்							
் மற்றவை	····à a ra min manadiù i	எதிர்பார்க்கப்ப	- ലിയ	நிபந்தனைகளின் கீழ் பாதுகாப்ப						
(மயக்கத்துடன்)	யக்க மருந்து கவனிப்பு	மேக்வுகள் ஜொபாக இப்ப	_ பசாகா	ருண தூக்கத்தைப்போன்ற கவடை	லயும் ஒளியும் குறைந்	து வருகிறது				
மாற்றுகள் 🗌 பொதுவான ப	NULĖK IDKĖKI	நுப்பம்	கையி	ின் நரம்பில் மருந்து செலுத்தப்ப(ලිස්තුනු					
	மயகை மருந்து இவ்விடைவெளி மயக்க மருந்து	அபாயங்கள்	т நீண்ட	நீண்ட கால மயக்கம், காற்றுப்பாதை கட்டுப்பாடு தேவை						
் மற்றகைவ		நன்மைகள்		லை இலவசம், ஆரம்ப கால வெளி	யேற்றம்					
மயக்கம் இல்லா	யக்க மருந்து கவனிப்பு ாமல்)	எதிர்பார்க்கப்ப முடிவுகள்	1 (5,600)	னியில் மாற்றங்கள் இல்லை						
மாற்றுகள் பொதுவான	ப்படக்க மகுக்கட்	நுப்பம்	இல்ன							
🔲 இலேசான ம		அபாயங்கள்		ாளிக்கு வலி மற்றும் கவலை இரு	க்கலாம்					
மற்றவை		நன்மைகள்	ஆரம்	ப வெளியேற்றம்						
பிறப்புக்கு முந்தை	ய / ஆரம்பகால குழந்தை	பருவ மயக்க ம	குள்கு							
பருவத்தில் ஆ ★ நான் / மேற்ல	ஆழமான மயக்கத்துடன் நீ கூறிய நோயாளி / பெயரி	ண்ட அல்லது மீ டப்பட்ட நோயா	ீண்டும் மீன் எளியின் பிர	விளைவுகள் பொது மயக்க மருந்த எடும் மீண்டும் வெளிப்படுதல் தீநிதி, இந்த வடிவத்தீல் கைபெழு	த்தீடப்பட்ட தேதீ, மனர்					
1			_	கு மேற்பட்டவன் என்று இதன்மூல						
மேற்கூறிய செயல்	பாட்டிற்கு (எஸ்) / நடைமுல	றற (கள்) எனக்கு	த தெரிந்துவி	பிட்டது. நான் தானாக முன்வந்து எ	ரைது ஒப்புதலை வழங்	த கிறேன்				
டாக்டர் (டாக்டர்) டி.	அல்லது டி–யில் கூறப்பட்	ட செயல்பாடு /	/ പ്രമൈധ്രത്യ	றபை செய்வதற்கு அறுவை சிகிச	ഞச செயல்முறையை	ச் செய்வதற்கான டா	க்டர் பெயர்,			
			-	கள் மற்றும் சிக்கல்கள் மற்றும் சா						
	- @	- @		ு∸ா வகவர்சில் கைபெ யுந த்திர ்	····· Pool is on Africa	ு 40 . ங. ஸ்.லா.க் மிர	-tulius manda			
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	ுகாக்குவர் இயல்பு காக்	க்கியமான அபா	ாயங்கள் மர்	ற்றும் சிக்கல்கள், நோக்கம் கொல		ார்க்கப்பட்ட பின் நக				
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	கள் மற்றும் தீட்டமிடப்பட்ட க்கப்பட்டுள்ள தகவல்கணை	செயல்பாடு/ ந ள அவர் /அவஎ்	ைமுறைக் ர முழுமைய		ன் நம்புகீறேன்.	· · · · · · · · · · · · · · · · · · ·	ள்ளார். இந்த			





ANAESTHESIA RECORD

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Every heart heat counts

(A Unit of United Alliance Healthcare Pvt Ltd)		Every heart beat counts
Mr. KALIYAN S	Type of Surgery : □	Day Care ¹☑ Elective ☐ Emergency
71/Malc/MHI202381394	Blood Group の十元	Height 16 cms Weight 63 kgs
27/12/2023/IPH2023002614 Dr.ANBARASU MOHANRAJ	Pre-Operative Diagn	osis: , 3m, HT : Of BOA,
		Anaesthetic Plan
ASA Grade: 🗆 1 🗆 II 🗆 III 🗆 IV 🗆 V 🗆 I	Proposed Surgery:	Anaesthetic Flan
Histøry of Present Illness:	COMORBIDITY	Present Medication :
☑ ANGINA	⊞HT □ SMO	
☐ DYSPNOEA ☐ SYNCOPE		ا ماء ا
☐ MI ☐ CCF	☐ ASTHMA / COPD ☐ GERI☐ HYPO THYROID ☐ CKD	
☐ OTHERS		Anti Platelet Stopped on :
Previous Surgery :	☐ EPILEPSY ☐	Algram 23/12/23
Physical Examination : ☐ JAUNDICE ☐ PEDEL OEDEMA	SYSTEMC EXAMINATE	
☐ CYANOSIS ☐ CAROTID BRUIT	CVS: 3197 RS: lead	CNS: Wal-
☐ CLUBBING	RS: clew	Others: WW2.
HR: 60 20 NIBP: 130/70 W	spo	2: 98-/, TEMP: -
INVESTIGATION	SEROLOGY /	ANGIO (1) onzum 90 1/1 LAO 70 1/1
HB : TBILIRUBIN : O' T3	: SEROLOGY Nonsuctive	PPA 99 1/4 - TANT - W
PLAT : 35250 1.D. : 0/10 T4	: 45 7 Urine:	ECG NSP TMT + 4
UREA: 40 D. :0.08 TSH	3,96	CXR WWL
A TODOTENIO 1716	c: <u>615</u>	CXR JANN L
ارو بال Na+ : ارو بال S.ALBUMIN : 4 الرو بال الم	Others:	ECHO 1≥F 611/1
K+ : 456 PTT/INR 13.5/ 12.1	= 1.0	ECHO ET 6.7.
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Neck Movement いかん Noticel Bi	e vertibet apples.	
Till Bibliotic	om: 12 mid wight.	
Pre Medication :	· ·	·
Night Before Surgery: tal. Alford 0.50	of + Tab-Painter	Blood Reservation PCV : まんだ・ Platelet :
Day of Surgery tal, Albanary 0,50% &	of at SAM!	FFP : CRYO :
Special Instruction :		Whole Blood:
Remarks:		1
Dr. A	SAMUEL SYLVESTE	ER L
Anaesthetist Name with Reg.No. :	Reg. No: 43570	Signature :

Da 出去	ate: Anaesthetist	DR.AJ	EETHA		Surgeo	nDR.A	NBARA	Su,DR	.PRAVEEN	Anaesti GA V	nesia Tech Regional [-
	RE INDUCTION AN				MONITO	ORS AND	EQUIP	MENTS	-	RAL ANAES	STHESIA	
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Sigi	ne:	Name:	194 A	ETHA	Foley Ca	theter 🔲	Nerve Stim	ulator	Intubation: Orall كاله CL Grade: ا			UFEDI
- IIIm				. ٠	ŢEE		Others:		Any difficulties ar	nd accessories:		
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ANAESTHE	SIOLOG	SIST NA	ME:	1617	eg. No: 74	71 SI	GNATURE	=		

ANAESTHESIOLOGIST NAME: REG.NO.

POST OPERATIVE PLAN												
Transfer to: SICU Others, specify:												
Arrival in Recovery / ICU Time: 12.50 SpO ₂ : 100 % HR: 57 beats/min Rhythm: SINUS RR: 14 breaths/min ABP: 137 55 mmHg CVP: 4 mmHg PAP: mmHg C.O: L/min Conscious state: SDMED DATURATED Pain score:												
VENTILATOR SETTINGS: IONOTROPES:												
Mode -s	(MV(Hz)#25 MV - :7,6 1/min	-NIC-										
POST OP ORDERS: TO DO ABGI, ACT, CBG, CXR CONTINUE MONITORING THE VITALS WEAN AND EXTUBRIE ONCE PATIENT GUT AWAKE												
MODIFIED ALDRETE'S SCO	RE (Score against each criteria)											
CRITERIA	PARAMETER		Scale									
Activity, able to move, voluntarily or on command	4 extremities 2 extremities No		1 0	Total Score :								
Breathing	Able to breath deeply and concept Dyspnea, shallow or limited Apnea		1 0	Patient fit for discharge: □XES □NO								
Consciousnesss	Fully awake Arousable on calling unresponsive		1 0									
Circulation (Blood Pressure)	+20% of pre-anaesthesia level +20% to 49% of pre-anaesthe +50% of pre-anaesthesia level	esia level	1 0									
SPO ₂	Maintains SPO ₂ >92% in amb Maintains SPO ₂ > 90P% with Maintains SPO ₂ <90% with O		1 0									
TIO	Maintains SPO ₂ > 90P% with O Maintains SPO ₂ < 90% with O LITTOILA Reg. No: 74	IA. P.K 4617	Signa	ature								

বesthetist Name & Reg.No. :

Signature



Loterd well



OPERATION NOTES

		function. DOB WHITE Dr. ANBARASU MOHANRAJ
	o 2 3	Please tick the type of procedure : Closed ☑ Open □
Operation Commenced: 9・45	Operation Completed:	Nature of R-30 Anaesthetic: Ganual
Surgeons Dr. Anderson / Dr.	Proven / PA- Kerthika	Perfusionist
Anaesthetist Dr. Afeetha Dr.	Sylvester.	Nurse Ms- Abitha
Incision Midline Steenstony		
Cannulation	Arterial	Venous
Oxygenator		Stemotomy - Thymus dissetted - vertical
Total CPB Time	pericardotomy - Target	assessed - LIMB and Lt SVG houses led
Total ACC Time	Systemic happonistion	- LIMA devided and proposed -
Total TCA Time	LIMA anastronosed to	s Loo - SUG anatomored to OM -
Findings and Relevant Details:		to PDA - Peniaorties for desiel - Dero
~ 1. 12 2 mm	applied - Two As	rteliny with 4:5 mm punch - Roximal
Lt Na of good colone - 4mm Targets LAD - 1.5 Healthy OM - 1.25 Athresolvesis	anosterness - Proton	ine - Hernostesin checked - Drawns a World with NO-6 steel wire - wound

POST-BY P	PASS HAEMODY	NAMICS				,	
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Me Pe	nest – (î) L+ P ediastinal <u>– (î)</u> ericardial thers	leurel					
Sponge Cou	nt: Coxect.		Dr. A nbaras Reg No	: 55476			
Surgeon:	Dr. Anbaras	u Mohanra	A.	•		. Date:28/12/20	3







OPERATION NOTES

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

NAME: Mr. KALIYAN.S	AGE/GENDER: 71 Years / MALE
UHID NO: MHI202381394	IP NO : IPH2023002614
DOA: 27/12/2023	DOS:28/12/2023
SURGEON: DR. ANBARASU MOHANRAJ	ANESTHETIST: DR. SYLVESTER/DR. AJEETHA
ASSISTED BY: DR. PRAVEEN JEYAKUMAR	PHYSICIANASSOCIATE: MS. KARTHIKA
SCRUB NURSE: MS. ABITHA	

DIAGNOSIS:

TRIPLE VESSEL CORONARY ARTERY DISEASE

CRITICAL LEFT MAIN DISEASE

GOOD LEFT VENTRICULAR FUNCTION

TYPE II DIABETES MELLITUS

SYSTEMIC HYPERTENSION

DYSLIPIDEMIA

CLASS II – III ANGINA

SURGERY DONE:

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 3

LIMA TO LAD

SVG TO OM

SVG TO PDA

FINDINGS:

Good myocardial contractions

Scarred inferolateral wall

LIMA - 1.75mm, Good quality, good flow

SVG - 1.75mm, from left leg, Good quality

044-26530011 | 044-2473 4455 |

LAD – 2.0mm, Healthy target

OM -1.6mm, Plaques (+)

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

🗗 @MedwayHospitals (C) @medwayhospitals

medway-hospitals

@medwayhospitals



Medway Group of Hospitals Kumbakonam Chengalpattu Villupuram

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

Kodambakkam

044-2473 4455

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

044-27426829

04146-242000

Medway Centre of Excellence (Chennai)





PDA – 2.0mm, Healthy target

Good distal run off in all the grafts

PROCEDURE:

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

Heart positioned and stabilized with myocardial stabilizer for OMgrafting. Arteriotomy was madeand 1.25mm intracoronary shunt was inserted. The end of the saphenous veinwas anastomosed to the side of the OM artery with 7-0 prolene suture. (SVGTO OM)

Heart re-positioned and stabilized with myocardial stabilizer for LAD grafting. Arteriotomy was made and 1.75mm intracoronary shunt was inserted. The end of the linitual LIMA was anastomosed to the side of the LAD artery with 7-0 prolene suture.(LIMA TO LAD)

Heart positioned and stabilized with myocardial stabilizer for PDAgrafting. Arteriotomy was made and 1.5mm intracoronary shunt was inserted. The end of the saphenous veinwas anastomosed to the side of the PDA artery with 7-0 prolene suture. (SVG TO PDA)

Aorta occluded partially. Two 4mm holes were made on the aorta with aortic punch. Proximal anastomosis of vein grafts done onto aorta with 6-0 prolene suture. Protamine administered. Hemostasis secured. Pericardiumreapproximated partially.Routine chest closure done with one mediastinal andone left pleural drain tubes insitu

SUPPORTS:

Hewas shifted to ICU with nil support

CONSÚLTANT SIGNATURE

Dr. Anbarasu Mohan Raj, MS, DNB, M.Ch (CTVS), FRCS (Glasg) Director and Clinical lead – Cardio Vascular and Thoracic Surgery

> Dr. ANBARASU MOHANRAJ Reg. No: 55476

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

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medway-hospitals

@medwayhospitals

94457 94457 1800 572 3003

Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

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



Mr.KALIYAN S 71/Malc/MHI202381394 27/12/2023/IPH2023002614 Dr.Anbarasu mohanraj



#9, 1st Main Road, United India Colony, Kodambakkam, Chennal - 600024. Tel: 044 - 4310 8959
Triple Vessel Coronan Arten Disease Critical Left Main Dissau
Critical Left Main Derson
Good LV Countins.
Datelin Mellitan
Systemis Hyperternen
Left Subclavian Left Internal Mammary
Aorta
Left Main Coronary
Right Coronary Obtuse Marginal Diagonal Anterior Descending
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Operation Performed Off PUMP CORDULARS ARTERS BYPAG CONFIDE SURCESSON PONTO CONFIDENCE PONT
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SAFE PROCEDURE CHECKLIST Adapted from WHO Safe Surgery Checklist



Mr.KALIYAN S

71/Mule/MHI202381394

Name of the Procedure:	Pass (readed of	Location: CTOT-OTI	Date & Time: 2	8/12/2023/14/2023/14/2023002614
Does the Procedure involve	1	1.040		Dr.Anbarasu mohanraj
SIGN IN 6 20 Before Induction of Procedural S	edation	TIME OUT ! A L L A After procedural Sedation and before procedure		SIGN OUT : 19:45 When Doctor indicates that the Procedure is completed
(Anaesthetist / Qualified Physicia Sedation + Nurse + Technician + Do		(Anaesthetist or Qualified Physician	ll Sedation + Nurse + Technician + Doctor ure	
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	□¥es	Identity by two identifiers	□Yes	Name of the Procedure done written down
Procedure	☐Yes ^	Procedures	□Yes	Name and site of all specimens / investigations ☐ Yes ☐ NA
Side	□Rt □H1 □NA	Side	□Rt □Lt □NA	confirms labeling and sent to lab
	Chear veg	Expected Blood loss 2 oom		
Consent	Yes ()	Position	☐Yes	Any recovery concerns : Yes None
Known Allergy	☐ Yes ☐ Notenour	Consent	☐ Yes_	If Yes, Pls. specify:
	If yes, plaese specify	Required equipment and implants available	□Yes □ NA	
Difficult airway / aspiration risk	No ☐ Yes, equipment	Essential Imaging displayed	□Yes □ NA	
/ dentures	and assistance available	Antibiotic prophylaxis within last 60 minutes	□Yes □NA	
Possibility of hypothermia	☐ No ☐ Yes, warmer in place	Name of the Antibiotic given	P 1. 15 9 R 9	Any Equipment / instrument problem that needs to be
/		Venous Thromboembolism Prophylaxis Provided	☐ Yes ☐ NA	Naduressed: ☐ Yes ☐ None If Yes, Pls. specify:
All concerned anesthesia equipment	and medication check complete	Anticipated duration briefed	□Yes,	
□Sp62 □NIBP □Other	s pls. specify	Anticipated blood loss briefed	□Yes □NA	_
Pre OP medication taken	∐Yes □ No	Adequate fluids and blood available	□Yes □ NA	
		Team briefed on any critical or unexpected steps	⊒Yes	Corrective action :
Required equipment for procedure available	☑ Yes □ NA	For procedural sedation cases Any patient specific concerns :	☐ Yes ☐ None	Stonge Graver, Instrument,
procedure available		Intra procedure glycernic control	Yes PINA	
		Any concerns about sterility	Yes Mone	Sponge Grave, Instrument, Needly courts are correct
Anaesthetist / Door giving Procedural Sedativit Date :	Doctor performing the Procedure:	Nurse: Abirka Te	echnician :	Others Please Specify:
Date: DR Thomas	Date:	Date: 26 12 0	ate: 25/12/02	Moole Date: 18/11/28
Time: 20/ 12/25 10.	Time:	Time: 4 12:40 Ti	me:	Time: & _ (









The wai Mr. KALIYAN S
(A Unit of Unit 71 / Main / MR 1202221204

71/Malc/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ

T'S INFORMATION SHEET

NAME WASHINGTON MOHANKAJ	<u> </u>	AGE / SEX `	٠,	UHID 1	NO	
		, ,				
					=	

CONSULTANT	SURGEON	ANAESTHETIST				
DR. ANBARASU	DR: ANBARASU	De. AJEETHA				
DIAGNOSIS (In Capital Letters)	1. CAD - TUD ; LEFT MAIN					
	2. NORMAL LV SI	2. NORMAL W SYSTOUL FUNCTION				
	3. GRADE-I DIASTOUL DYSFUNCTION					
	4. NORMAL RU SYSTOUL FUNCTION					
	5. TRIVIAL MR, AR NO PAH					
·	6. TYPE-IT DM HTM DYSUPIDEMIA					
	7. EF-61.1.					
	8.					
PRESENT PROCEDURE/ SURGERY	opcabx 3 utri Lima - Lad Svu - Om Svu - PDA	FIS				
PREVIOUS PROCEDURE/ SURGERY	BIL CATARACT :	SURVIERY DONE AT				
CONTACT NO. & RELATIONSHIP	1. MR-SARAVANAN 9486659113	2. ME. SARAVANAN 9384305551				

MEDICATION HISTORY

						•
S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	27/12/23	TAB RUDIMIN	ITAB	Plo	1-0-07	,
2	27/12/23	TAB. SAPBITPATE	5mg	Plo	202	
3	27/12/23	TAB GIN SURBINGATE	d Libma	Plo	1-0-1	Continue
4	वेत्रीभ23	TAB. METAPPOLO	12:5mg	Plo	1-0-1	
5	2712/23	TAB, SKAT.	ITAB.	Plo	1-0-0	
6						
7						
8).		•
9	·					
10	-					9
	ANTIPA	ATELET STOPPED C	mi - 23	2 112/2	<u> </u>	
	2 11 20 11 0	かにに ついしひ		11725		
S.No	STARTED ON	CURRENT MEDICATION (After Admission)		Route	Frequency	STOPPED ON
S.No	STARTED	CURRENT MEDICATION (After Admission)			Frequency	
	STARTED ON	CURRENT MEDICATION	Dose Hemore	Route		
1	STARTED ON 29/12/23	CURRENT MEDICATION (After Admission)	Dose Homor	Route		
1 2	STARTED ON 29/12/23	CURRENT MEDICATION (After Admission) TAB - FRUSEMIDE TAB - OPIRANOIACION	Dose 40mor 25mor	Route P10 P10	1-1-0	
2	STARTED ON 29/12/23 29/12/23	CURRENT MEDICATION (After Admission) THB - FRUSETINDE THB - SEPLEX FORTE	Dose 40mbl 174B 40mbl	Route Plo Plo Plo	1-1-0	
1 2 3 4	STARTED ON 29/12/23 29/12/23 29/12/23	CURRENT MEDICATION (After Admission) TAB - FRUCETINDE TAB - OPPRANOIACION TAB - BEDLEX FORTE TAB - CINPLET + APPRA	Dose 40mbl 174B 40mbl	Route Plo Plo Plo	1-1-0	ON
1 2 3 4 5	STARTED ON 29/12/23 29/12/23 29/12/23.	CURRENT MEDICATION (After Admission) TAB - FRUSEMUDE TAB - OPIRAMOTATION TAB - BEPLEX FORTE TAB - CUPILET + APPRIL TAB - FRORVASTATIN	Dose Tomor The Assument of t	Route Plo Plo Plo Plo	1-1-0 1-0-0 0-0-1 1-1-1 0-0-1	ON
1 2 3 4 5	STARTED ON 29/12/23 29/12/23 29/12/23 29/12/23	CURRENT MEDICATION (After Admission) THB - FRUGETINDE THB - OPPRENDENTE THR - REPLEX FORTE THR - CUPILET + APPRENDENTE THR - CUPILET + APPREN	Dose Tomor The Assument of t	Route Plo Plo Plo Plo Plo	1-1-0 1-0-0 0-0-1 1-1-1 0-0-1	ON
1 2 3 4 5 6	STARTED ON 29/12/23 29/12/23 29/12/23 29/12/23 29/12/23	CURRENT MEDICATION (After Admission) THB - FRUCETIONE THB - OPPRENDENTE THR - REPLEX FORTE THR - CUPILET + APPRENDENTE THR - CU	Dose	Route Plo Plo Plo Plo Plo	1-1-0 1-0-0 0-0-1 1-1-1 0-0-1	ON
1 2 3 4 5 6 7 8	STARTED ON 29/12/23 29/12/23 29/12/23 29/12/23 29/12/23	CURRENT MEDICATION (After Admission) TAB - FRUSEMIDE TAB - OPPRANOISE TAB - BEPLEX FORTE TAB - CIMPLET + APPRA TAB - PARA SUP - CREMATEINFLU MEB - LEVOLIN	Dose	Route Plo Plo Plo Plo Plo Plo Plo	1-1-0 1-0-0 1-0-0 0-0-1 1-1-1 0-0-1 26thy.	ON

ANY RELEVANT INFORMATION:

Admission / OT Receival	Condition of the Patie	ent:	ON VENT 2. Oriented / Disoriented			
Date and Time: 28/12/23 AT	Stable / Unstable Conscious / Semice					
12.45 From: CT To: SICU	4. Febrile / A febrile	5. Intubated / Extubated				
Transfer Out	Condition of the Pation	ent:				
Date and Time: 30 2 2 3	1. Stable / Unstable		2. Oriented / Disoriented			
01 10.30	3. Conscious / Semice					
From: SDICUTO: 10A	4. Febrile / A febrile		5. Intubated / Extubated			
Transfer In	Condition of the Patie	ent :				
Date and Time :	1. Stable / Unstable		2. Oriented / Disoriented			
Duto and Time	3. Conscious / Semice					
From: To:	4. Febrile / A febrile		5. Intubated / Extubated			
1) Known Case of	Year	Months	Days			
Diabetic Mellitus	1					
2) Known Case of	15 YEARS					
Hypertension	15 YEARS					
3) Known Case of Bronchial Asthma/COPD		<u>. </u>				
	·—					
4) Known Case Of Others		***				
		•				
	☐ Yes	, No				
Denture	Permanent Fixátio					
	Temporary Fixation: Present / Absent					
	☐ Yes	No '	-			
Allergic Reaction : Drugs/Food	If you means mention about Drug / Food Name:					
	7F00d IT you means mention about Drug 7 Food Name.					
1 11 11 11	professional design					
70	☐ Yes					
Pressure Ulcer Present	If you means mention a	bout Grade: 1 / 2 /3 /	4 & Site:			

ANY RELEVANT INFORMATION:

., : : : : : : : : : : : : : : : : : : :					Sign With Date
Peripheral Cannulation	1. Site: RT METHORPEL	Inserted Date and Time		1. Removed on:	NOO- 024
٠	2. one:	2. Inserted Date	e and Time	2. Removed on:	21124
	3. Site:	3. Inserted Date	e and Time	3. Removed on :	
Neek Line : IJL / EJL	Site: RT DJV	Inserted Date a		Removed on 30/12/23 at 9.30	Paus ta
Arterial Line : Right/Left	Site: 17 RADIAL	Inserted Date a		Removed on 39 12 23 of 9.45	Clark &
Sheath Arterial / Venous:	Site:	Inserted Date a		Removed on	
Pressure Bandage	Site:	Inserted Date a	nd Time	Removed on	
Drain Site	1. Mediastinal: Inser	ft : Inserted Dat	te and Time	Removed on Removed on 29 12 23 @9.1	Office of A
Urinary Catheterization	Inserted Date and Tim		Removed or		276
Nasal / Oral Gastric Tube	28/12/23	18-00	Removed or	n	部分
Intubation Date and Time	Extubation Date And	Time 5 mins	Reintubatio	n Date And Time	
Other Information	ELH DONE On:-	20/12/23	łr-75 m	H	
	CAM DONE ON:- SUREENIMU EUM OFF CHES	TO Done	THE	complaints	节







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

Mr.KALIYAN S 71/Malc/MHI202381394	T'S INFORMATION SHEET
NAME Dr.ANBARASU MOHANRAJ	AGE/SEX 7 M UHID NO 202381394
	SURGEON . ANAESTHETIST
Dr. ANBARASU	Dr. ANBARASU Dr. SYLVESTER
DIAGNOSIS (In Capital Letters)	1. CAD-TVD
	2. T2Dm/HTN/Dystipidemia
., .	3.
•	4.
	5.
	6.
et et i	
- I.e.	
· . ,	8.
PRESENTED O CERTIFICATION	
PRESENT PROCEDURE/ SURGERY	CABGUGA
PREVIOUS PROCEDURE/ SURGERY	B/c Cataract Surgery done at 2019, 2022.
CONTACT NO. & RELATIONSHIP	1. SON IN LAW 2. 9118659113 GARAVANIAN)

MEDICATION HISTORY

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	118/23.	a. Telma	Young	Ph	to	23).
2	الاستاد	Tudapa tro	ldab	Pb	100	23/12
3		T. Ecospin Av	Fory	Pb	00	23/12
4	1 18/23	F. Rudimin	1 tab	i.p.b	1	24/10
5	٨	1. Sorbitrate	المرد	sh	દિન્દે	
6	ካ	T. 9TN	2.6 mg	Pla	1-01	Dem
7	h	T. MET ZOK	12.0mg	Plo	1	9 —
8	1/8/23.	T. 3 KAT	ltab	Pb	١٥٥	3 -
9						
10		_				

S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	1/8/23.	T. RUDIMIN	1tab	Plo	100	_
2	4	J. SORBITRATE	Smg.	Plo	(203)	-
3	n	J. GTN	2.6mg	Plo	Haj	<u> </u>
4	ч	T. METZOK	اعالمه	Pb	201	_
5	4	T-3KAT	Itab	Ph	Loo	_
6						
7	in the second	No. 200				
8			-	· ·		
9				,		
10				,		

ANY RELEVANT INFORMATION:

Admission / OT Receival	Condition of the Patient :			
Date and Time :	Stable / Unstable Conscious / Semiconscious / Unconscious		2 Oriented / Disoriented	
From: To:	4. Febrile A febrile		5. Intubated / Extubated	
Transfer Out	Condition of the Patie	ent :		
Date and Time :	1. Stable / Unstable		2. Oriented / Disoriented	
	3. Conscious / Semico	onscious / Unconscious		
From: To:	4. Febrile / A febrile		5. Intubated / Extubated	
Transfer In	Condition of the Patie	ent:		
Date and Time :	1. Stable / Unstable		2. Oriented / Disoriented	
	3. Conscious / Semico	onscious / Unconscious		
From: To:	4. Febrile / A febrile		5. Intubated / Extubated	
1) Known Case of	Year	Months	Days	
Diabetic Mellitus 2) Known Case of	1540			
Hypertension	lsyn			
3) Known Case of Bronchial Asthma/COPD	_			
4) Known Case Of Others			 	
	☐ Yes	□N₀		
Denture	☐ Permanent Fixation			
	☐ Temporary Fixation : Present / Absent			
	Yes	□ No		
Allergic Reaction : Drugs/Food				
	☐ Yes	✓ No		
Pressure Ulcer Present	If you means mention a	,	4 & Site:	
	-			

ANY RELEVANT INFORMATION:

		† 1			Sign With Date
Peripheral Cannulation	1. Site:	1. Inserted Da	te and Time	1. Removed on :	
	2. Site:	2. Inserted Da	te and Time	2. Removed on :	
	3. Site:	3. Inserted Da	te and Time	3. Removed on :	
Neek Line : IJL / EJL	Site:	Inserted Date	and Time	Removed on	
Arterial Line : Right/Left	Site:	Inserted Date	and Time	Removed on	
Sheath Arterial / Venous:	Site:	Inserted Date	and Time	Removed on	
Pressure Bandage	Site:	Inserted Date	and Time	Removed on	
Drain Site	1. Mediastinal: Inserted Date and Tim		ime	Removed on	
	2. Pleural Right / Let	ft: Inserted Da	ate and Time	Removed on	
Urinary Catheterization	Inserted Date and Tin	ne	Removed or	n	
Nasal / Oral Gastric Tube	Inserted Date and Tin	ne	Removed or	n .	
Intubation Date and Time	Extubation Date And	Гіте	Reintubation Date And Time		
Other Information	27/12/23 10 pcv R	eservah	on do	ne with vanya	Carl Bar



Mr.KALIYAN S

71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj

MHI/IP/2022/067



CONSENT FOR BLOOD / BLOOD COMPONENTS

A Blood transfusion is life saving medical procedure, prescribed by a physician. Blood can be given 'whole' but more often a component or combination of component is transfused. Among the most common components are:

Red Cells for bleeding or low hemoglobin

Platelets for bleeding or low counts

Plasma for restoring blood volume or providing clotting factors

Cryoprecipitate for special clotting factors

The Doctor has explained the benefits that are expected from my/the patients being transfused as well as the risk are:

- I have been informed the transfusion option available, which may include banked blood (allogenic) provided by voluntary donors or self-donation (autologous). If an emergency condition exists, banked blood will be invariably be used. Self-donation is possible if time permits.
- 2. I have been informed that despite careful screening in accordance with national regulations, there are rare instances of life threatening infections such as AIDS, Hepatitis and other viruses or diseases as yet unknown. I understand that there is no practical way to eliminate all risks. I also understand that unpredictable reactions may occur which include but are not limited to, fever, rash, and shortness of breath, shock and in rare occasions, death.
- Expected benefits of the transfusion may include minimizing shock, brain and other organ damage, hastening recovery and limiting blood loss, however, I understand that there are no guarantees offered as to the expected benefits.
- 4. I have had the opportunity to ask questions about transfusions, alternate forms of treatment, risks of non-treatment, the procedures to be used, and the relative risks and hazards involved and I believe that I have sufficient knowledge to make an informed decision.
- 5. I agree/Not agree the administration of blood and/or components in the interest of proper medical care, with my signature I give consent to administering blood products for myself or for the patients. I agree this informed consent may serve for consent to give additional necessary blood products for a time certain to end with this hospitalization or for the complete course of this illness. If I have been advised that the future need for transfusion blood products is quiet likely and possibly on a recurrent basis but still related to the same illness.

	Patients name 1-3-law
Doctor 2570	Patient signature Salayana or Guardians name KISALAYANAN
Doctor	or Guardians name KISALAYADAD
Date 21/12/23	Guardians signature
	Relationship to patient
formed general make their 11	

Informed consent not obtained because of a life threatening/emergency medical condition. I have provided the patient information sufficient to be considered informed consent and I have proceeded with ordering blood products to be administered in sufficient quantity to alter, improved or reverse a life-threatening/emergent medical condition.

Time:	Date:	Doctors Signature:
-------	-------	--------------------



நோயாளியின் பெயர் :

தேதி:



ஒப்புதல் : இரத்தம் / இரத்தத்தீன் பாகங்களை செலுத்துதல்

இரத்தம் செலுத்துதல் என்பது, மருத்துவரால் பரிந்துரைக்கப்படுகின்ற ஒர் உயிர் காக்கும் மருத்துவ செயல்முறையாகும். முமுமையான இரத்தம் அளிக்கப்படனாம் என்றாலும்,பெரும்பாலும் ஒரு பாகம் அல்லது பாகங்களின் கலவை செலுத்தப்படுகிறது. மிகப் பொதுவான பாகங்களில் கீழ்கண்டவை அடங்கும்.

சிவப்பு அணுக்கள் இரத்தப்போக்கு அல்லது குறைந்த ஹீமோகுளோபினுக்கு தட்டணுக்கள் இரத்தப்போக்கு அல்லது குறைந்த எண்ணிக்கைக்கு

குருதிநீர் இரத்த கன அளவை மீட்டமைப்பதற்கு அல்லது உறைவு அம்சங்களை வழங்குவதற்கு

கிரையோபிரைஸிபிடேட் சிறப்பு உறைவு அம்சங்களுக்காக

எனக்கு/நோயாளிகளுக்கு இரத்தம் செலுத்தப்படுவதன் மூலம் எதீர்பார்க்கப்படும் நன்மைகள் மட்டுமின்றி இடர்களையும் மருத்துவர் விளக்கியுள்ளார்

- இரத்தம் செலுத்துவதில் கிடைக்கின்ற விருப்பத்தேர்வு பற்றி எனக்கு தகவலளிக்கப்பட்டுள்ளது. இதில் தன்னார்வ தானமளிப்பவர்கள் வழங்கியுள்ள வங்கியிலுள்ள இரத்தம் (அலோஜெனிக்) அல்லது சுயமாக தானமளித்தல் (ஆட்டோலோகஸ்) ஆகியவை அடங்கும். ஓர் அவசரநிலையில், வங்கி இரத்தம்தான் பயன்படுத்தப்பட வேண்டியிருக்கும், நேரம் கிடைக்கும் பட்சத்தில் சுய தானமளிப்பதற்கு வாய்ப்புள்ளது.
- 2. தேசிய விதிமுறைகளுக்கேற்ப கவனத்துடன் முன்சோதனை செய்யப்பட்டிருந்தாலும். உயிருக்கு ஆபத்தை விளைவிக்கக்கூடிய தொற்றுக்கான எய்டன், ஹெபடைடின் மற்றும் இதர வைரஸ்கள் அல்லது இதுவரை அறியப்படாத நோய்கள் ஏற்பட்டுள்ள அரிதான நிகழ்வுகளும் உள்ளன. எல்லாவிதமான இடர்களையும் நீக்குவது என்பது நடைமுறைக்கு இயலாத ஒன்றாகும் என்பதையும் நான் புரிந்து கொள்கிறேன். கணிக்க முடியாத எதிர்விளைவுகளும் தோன்றலாம். இவை காய்ச்சல், பொரிப்பு, மூச்சுத்திணறல், அதிர்ச்சி மற்றும் அரிதான நிகழ்வுகளில் இறப்பு ஆகியவற்றை உள்ளடக்கி, அந்த வரம்புக்குட்படாதவையாகவும் கூட இருக்கலாம் என்பதையும் நான் புரிந்து கொண்டேன்.
- 3. இரத்தம் செலுத்துவதன் மூலம் எதீர்பார்க்கப்படும் நன்மைகள். அதீர்ச்சி. மூளை மற்றும் இதர உறுப்புகளுக்கு ஏற்படும் சேதம் குறைக்கப்படுதல், குணமடைதலை துரிதப்படுத்துதல் மற்றும் இரத்தம் இழக்கப்படுவதைக் குறைத்தல் ஆகியவற்றை உள்ளடக்கியிருக்கலாம் என்றாலும், எதீர்பார்க்கப்படும் நன்மைகளுக்கு உத்தரவாதம் ஏதும் அளிக்கப்படவில்லை என்பதையும் நான் புரிந்து கொள்கீறேன்.
- 4. இரத்தம் செலுத்துதல், மாற்று சிகீச்சை முறைகள், சிகீச்சை எடுக்காமல் இருப்பதிலுள்ள அபாயங்கள், பயன்படுத்தவிருக்கும் செயல்முறைகள், மற்றும் இதிலுள்ள இடர்கள் மற்றும் அபாயங்கள் ஆகியவை பற்றிய கேள்விகள் கேட்பதற்கு எனக்கு வாய்ப்பிருந்தது. மேலும் தகவலறிந்த நிலையில் முடிவெடுப்பதற்கு ஏற்ப எனக்கு போதிய விவராங்கள் தெரிந்திருந்தன என்று நான் நம்புகிறேன்.
- 5. முறையான மருத்துவ பராமாிப்பின் பொருட்டு. இரத்தம் மற்றும் / அல்லது அதன் பாகங்கள் செலுத்தப்படுவதற்கு நான் ஒப்புக்கொள்வதுடன், எனது கையொப்பத்தின் மூலம் எனக்கு அல்லது நோயாளிகளுக்கு இரத்தப் பொருட்கள் செலுத்தப்படுத்துவதற்கு என் ஒப்புதலை அளிக்கிறேன். இதே நோய் தொடர்பாக, இரத்தப் பொருட்கள் செலுத்தப்படுவதற்கான எதிர்காலத் தேவைக்கு வாய்ப்புள்ளது மற்றும் அது தொடர் அடிப்படையில் இருக்கலாம் என்று எனக்குத் தெரிவிக்கப்பட்டிருக்குமானால், இந்த மருத்துவமனை சேர்ப்பின் குறிப்பிட்ட காலத்தில் முடிவடையும் வகையில் அல்லது இந்நோயின் முமுமையான காலகட்டத்திற்கும் தேவையான கூடுதல் இரத்தப் பொருட்கள் செலுத்தப்படுவதற்குரிய ஒப்புதலையும் இத்தகவலறிந்த ஒப்புதல் மூலம் வழங்குவதற்கு நான் ஒப்புக் கொள்கிறேன்.

நோயானியின் பெயர்.....

ச ாட்சி	நோயாளியின் கையொப்பம்	
மருத்துவர்	அல்லது பாதுகாவலரின் கையொப்பம்	
நேரம்	பாதுகாவலரின் கையொப்பம்	
தேதி	நோயாளியுடனான உறவு	
		•
உயிருக்கு ஆபத்தான / அவசரக்கால) மருத்துவ நீலை காரணமாகத் தகவலறிந்த ஒப்புதல் பெற	ப்படவில்லை. தகவறிந்த ஒப்புதலாகக் கருதப்படக்கூடிய அனவிற்கு
நான் போதிய அளவு தகவலை ரே	நாயாளிக்கு வழங்கிவிட்டேன். மேலும் ஓர் உயிருக்கு	ஆபத்தான / அவசரக்கால் மருத்துவ நிலையை மாற்றுவதற்கு
மேம்படுத்துவதற்கு. நேர்மாறாக ஆக	க்குவதற்கான போதிய அளவில் இரத்தப் பொருட்களை	வழங்குவதற்கான உத்தரவை வழங்கும் நடவடிக்கையை நான்
மேற்கொண்டுள்ளேன்.		• . •
•		
நேரம் :		

மருத்துவரின் கையொப்பம்.....



Patient Details (Affix Label here)

Name:

Mr.KALIYAN S

UHID: DOB:

71/Male/MHI202381394 27/12/2023/IPH2023002614

DOA: Consulta





IN-PATIENT INITIAL ASSESSMENT FORM - PHYSIOTHERAPY

Chief Complaints: PT Go throat pain (+)			
PI Go thatat kund)			
Occupation	I taka A sababa		
Occupation: Heavy Activity Moderate Activity Past Medical / Surgical History:	/ Light Activity		
Lich on 1 1500			
KIGO DI.			
klelo DM × 15ym Relelo HTN× 15ym. Klelo - CAD- LH+ TND.			
KICLO - CAD- LBI			
S/P -Ble Oatarac	t Surgery done at (2010, 2022)		
On Observation:			
Built: ☐ Thin ☐ Fair ☐ Well Built ☐ Obese Postural Deviation			
Deformity: ☐Yes ☐No Swelling: ☐Yes ☐No Gait Deviation: ☐Yes ☐No External Appliances: ☐Yes ☐No			
On Palpation:	☐ INSIGNIFICANT		
Tenderness: ☐ Yes ☐ No Warmth: ☐ Yes ☐ No Muscle sp Oedema: ☐ Yes ☐ No Crepitus: ☐ Yes ☐ No Tone: ☐ Norm			
FALL RISK SCREENING	al Linonnai		
Fall Risk Screening for Adults: Age more than 65 years	History of fall in last 3 months		
☐ Walks with assistance ☐	Any neurological problem		
In case of 2 or more criteria is met, initiate detailed fall assessm	nent and fall prevention protocol.		
Fall Risk Screening for Pediatrics: NU			
☐ H/O fall in last 3 months ☐ Neurological problem (<i>vertigo</i> , <i>seizure</i> , <i>etc</i>) ☐ Deranged mobility			
In case of 2 or more criteria is met, initiate detailed fall assessment and fall prevention protocol.			
Respiratory Status:	Brain Injury (if applicable): N U		
☐ Room Air ☐ O₂ Support ☐ Ventilatory Support ☐ BIPAP	☐ Traumatic ☐ Non Traumatic		
☐ Tracheal Mask ☐ Nasal Prongs ☐ Face Mask ☐ Mild ☐ Moderate ☐ Severe			
Intubated: Yes No Conscious Unconscious			
Tracheostomy: ☐ Yes ☐ No	GCS: E +V +M = RLA: levels		

Spine Injury: ☐ Present ☐ Absent	•			
AIS:ISNCSCI SCALE: NUL				
☐ Cervical ☐ Dorsal ☐ Lumbar ☐ Sacral ☐ Coccyx				
Associated Injuries: Speech impaired: ☐ Yes ☐ No				
Voluntary Movements: ☐ Present ☐ Absent Tone Mod	lified: ☐ Hypotonic ☐ Normal ☐ Hypertonic			
ASHWORTH SCALE: NIC				
☐ Tightness ☐ Contracture ☐ Deformity ☐ Sensory De	eficit			
Balance: ☐ Good ☐ Fair ☐ Poor Co-ordination: ☐ G	ood ☐ Fair ☐ Poor			
Functional Activities				
Self Care: ☑, Independent ☐ Dependent │ Bed Mobility:	: 🖸 Independent 🗆 Dependent			
Transfers: ☐Independent ☐ Dependent	☐ Independent ☐ Dependent			
FIM Score:				
Breathlessness (If applicable): NLL				
Dyspnoea Grading Scale:				
Abnormal Breathing Sounds: ☐Wheezing ☐Stridor ☐ C	Crackles ☐ Pleural Rub ☐ Pneumothorax Click ☐ Stertor			
Abnormal Breathing Pattern:				
Pain Assessment: Pain: ☐ Yes ☐ No				
Pain Score:				
	Scale ☐ Visual Analog Scale ☐ Wong-Baker Faces			
	Care Pain Observation Tool FLACC			
Location: Duration: F	requency: Character:			
☐ Acute ☐ Chronic ☐ Burning ☐ Aching ☐ R	adiating Numbness			
☐ Sharp ☐ Cramping ☐ Stabbing ☐ Crushing	}			
Aggravating Factors:	Relieving Factors:			

Examination /	Please tick and mention ab	normal findings only):					
☐ Range of M		,,,,,,,					
nange on w	Nomal						
	1.0000						
☐ Muscle Stre	engtn:						
	Normal						
☐ Reflexes:	۸. ۸						
	Normal						
- 1							
Plantar Respo	nse: ☑Diminished ☐Brisl	k 🗆 Clonus					
Biceps: □ bin	ninished 🗆 Brisk 🗀 Clonus	5					
Triceps: Dir	ninished Brisk DClonu	s					
Supinators:	∭Diminished □Brîsk □Cl	onus					
Knee: ☑ Dimi	nished Brisk DClonus				l		
Ankle: ☐∕Dimi	inished □Brisk □Clonus						
Sensation:	200d.						
Investigation & Findings:							
D:- CAD-LH+ TVD/TeDM/SHTN/ Dyslipidemia							
ı							
Physiotheran	v Management Plan	.			·		
Physiotherapy Management Plan: କ୍ଲେମ୍ବର							
- Someting vilence -							
- Sproonely successed - Sproonely successed to Bh chest wall - Arom to Bh viell - Maltization							
Appel to Ble Medle							
Mal A. Falian							
mayur soor							
	Signature	Name	Emp. No.	Date	Tlme		
Physiotherapist	(g. b. Akgh	ALUASH - GIE	0256	28/12/23	14:30		

RE-ASSESSMENT FORM					
Date & Time 29/12/23 4 10:00	Fall Risk Score: — Pain Score: 2/10 Surgical Situ Dain Pay - Das's Eulomyel - cheef Dennison done to Rh. cheef wolf - Spiromely en eulomyel - Active en to Bhe of sole - Mobilited to Char. - 70 Fayrone Folker ADL				
	Post Intervention Pain Score: 7	2/100 Cardio Puhnonany Pa			
Physiotherapist	J. mg	JULYAPACLANAN	2102		

٠.





Patient D<u>etails (Affix Label here)</u>

Name: Mr.KALIYAN S

UHID: 71/Malc/MHI202381394

DOB: 27/12/2023/IPH2023002614

DOA: Dr.ANBARASU MOHANRAJ

MHI/PHY/2022/050

Medway

Heart

Institute

ry heart beat counts

CONSENT FORM - PHYSIOTHERAPY

I, Valigam the Patient or representative of patient have (please tick the correct option above and below):
Read
I/We have been explained the current clinical condition of me/my patient Been explained this consent form in(Name of language) which I fully understand and understood
the information provided about Operation / procedure
Post operature cardiac Reluciosay Reliabilitation
(full name of operation / procedure given below in this consent form)
to Ble chest wall, Aron to Ble UL LL, Mobilization
to Rh alost wall. Arouto Ble UL fel, Molalization
10 01 (ALLE 170 OLD 17
I understand the intended benefits of undergoing the procedure . The intended benefits from this procedure are:
· · · · · · · · · · · · · · · · · · ·
To Puperous Joint Rox, To Puperous Lung Capacity of function' To Clean out lung secretion To purposer breaths
I understand that all procedures carry certain risks. The potential risks and complications from this procedure:
· · · · · · · · · · · · · · · · · · ·
Posici
I have been explained the implications of not undergoing this procedure and the alternative methods of treatment like;
, 4
Nul
I declare that I have received and fully understood the information provided in this consent form, that I have been given an opportunity to ask questions relating to my ailment, the operation / procedure being performed, its risks, consequences, alternatives, potential complications and intended benefits and recovery, and that all my questions
have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my signing this form.

Signature of Patie	Signature of Patient / Patient's Relative (only if Patient is unable to sign):							
Dr. AKASH : procedure on Arr	For the above mentioned operation(s) / procedure(s) that I have been made aware of, I give my consent voluntarily to Dr. HABH (name of doctor performing the operation / procedure) for carrying out the said operation / procedure on myself or my above named patient being fully aware of the nature, potential risks and complications, intended benefits and possible alternatives							
Mr. K.S	agarana.							
		ve, do further hereby declare that I am above 1 onsent without any fear, threat or false misconc		on the				
	Signature / Thumb Impression* Name Date Time							
Patient								
Surrogate/Guardian (if applicable #)	K. Gravan	(Write name and relationship with patient)	28/12/23	14:40				
Reason for surrogate consent	Patient is unable to give consent because:							
Witness	D. Sheeba.	D. sheeby.	28/12/23	الو:لوه				
Interpreter (if applicable)								
* Right Hand for Males & Left Hand for Females # Only if Patient is a minor or unable to give consent								

•

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

	Signature	Name	Reg. No.	Date	Time
Consent obtained by	G. E. Akad	AKASH G &	0251	28/12/23	Mileo
Procedure performed by	G. F. Alge	Aleasth G. E	025%	28/12/23	14 /40





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Mr.KALIYAN S

71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ

PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
28/12/23	16:50	S.B. AKASH	G.B. AROS
i		- PT extulated	MH10256
;		- BT foral (Noval Suctioning	r
		done giolded Hirele White	
		Secretion	
		- PT voice cleanfoundible	
		a por the land = zed	
!		- PT Comedad to 02 Maek:	
i		5 litres	
		- Spirometey es aucouraged	
į		- Spisonetey es aucouraged In: 600 cs Expilosec	
28/12/23	22 : 00	SB Zamanathan P	
		-DBE's encouraged	
		-Chest percussion to B/2 Chartwall	DALI
		-AROM ON'S to BL ULZU	MH102-60
•		Spirometry Go's encouraged Em: 600ce Gop: 600ce	
09/12/23-	6:00	SB Damanathan P	
		- DBE's encouraged - Chest percussion to Ble Chest wall	
		AROM Ex's to BL ULZU	mH10260
		-Spirometry to's encouraged	
		Ins: 6001 Exp: 60011	





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Mr.KALIYAN S

71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ

PHYSIOTHERAPY TREATMENT CHART

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
29/12/23	9300	S/B J. VI) AYARACIOUAN DBB Onlowyel	•
		- Chest Jermindon dove to Ble Chest wall - Spiromely En anlonged Fis-Goove Bin Goove - Active Oil to Ble UL & U	Mmcr2102
29/12/23	17200	S B AKASH -DEN encouraged - Sprometry eir encouraged Ins: booce Exp: booce - Chest percusion to Ble Chest Wall	Git Alead MH1028b
29/12/23	dd:00 	-AROM to Ble Vidle -PT Chavis Mobilized Pusible the -PT Mobilized Pusible -PT Mobili	MHLOZGO





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PHYSIOTHERAPY TREATMENT CHART

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Mr.KALIYAN S

71/Malc/MHi202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
30/12/23	6:00	Ols Ramanathan +	:
		- DBE'S encouraged - Churt parcuerion to BL chest will - Spirometry En's encouraged Ins: 600 a Gop: 600 a - Arom Go's to BL ULE U - Pt Chair mobilised	At 1 mH10266
30/12/23	91,00	SIB July ARACADAN - Cheft remudon due to Ble cheft wall	
		- Stiromely ent enlanged Hes-booke Rar-booke - Arom est enlanged to Ble UL & U - Patrick mobilised to chair.	J. my mmc-2102
30/12/23	17100	SIB AKASIA - Dren Europeraged - Sprondry en Europeraged In 1600CC Rap: 600Ce - Chest penanssian to the Chest wall - Arom to the Undle	GIF HOLED MH10286





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Mr.KALIYAN S

71/Malc/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ

		PHYSIOTHERAPY TREATMENT CHART	THE THE PROPERTY OF THE CONTRACT OF THE CHANGES
DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
3/10/23	@ ', <mark>@</mark>	TPT Mobilized She July AYARALAUAN	
31/01/23	(5,'00	- Steel Enbuyet - Cley runnbon done to Ste cleet wall - Stromely en enbuyet - Je-booce Reposee - Active en to Ble vis U - Deen enbuyet - Cleet runnbon done to Ble Cheet wall - Sphomely en enbuyet - Tes-booce Far booce - Active en to Ble vis U Culowyet - Petreet no Clast outstee - Petreet no Clast outstee - Le voon	J. my anne-2102





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PHYSIOTHERAPY TREATMENT CHART

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Mr.KALIYAN S

71/Malc/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj

DE LES COMPANION DE L'ANGLES D

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
10124	(6:00	SlB ARASIA - Deex curanger	G. 15-9/202 M. 10256
		- Dear Emanaged - Spronetry Eur Encouraged - Ins) Gooce Exp. Gooce	1
		- Cheet position - Aron to Bh vidle - Aron gaindinh emouraged - PT Stair dinh emouraged	·
01/01/24	16:00	SIB AKASH -DBOX EUROWROGES - Spideneby encouraged - Spideneby encouraged - The Gooce Exp: booce The Gooce to Ble	G7.13 Alast Martions 16
		SIB AKASH -DBOX Eurowaged - Spidenetry chrowaged - Spidenetry chrowaged - Spidenetry chrowaged - Spidenetry chrowaged - Fore books - Chest porcuelle to Ble - Akom to Ble Uldle - Akom to Ble Uldle - Fore admire given - How dint erroway	Pd
2/1/24	10,00	S/3 Ramanathan-T	
	ď	-DBES encounaged -Chext pencusion to 1812 Chut will AROM Eu's to 1812 UL 814 - Spinometry Exis cencounaged Ins: 600cc Exp: 600cc -Pl mobilised	#10260



. 1 to 1 to 1



Mr.KALIYAN S

71/Malc/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ

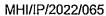
URINE ROUTINE ANALYSIS

MICROBIOLOGY SHEET

DIVINE ROOTINE ANAL	.1010 <u></u>	
DATE	20/12/23	
COLOUR	PAIL VELLOW	
REACTION	6.0	
SPECIFIC GRAVITY	1-010	
APPEARANCE	CLEAR	
ALBUMIN		
SUGAR	4-4	
ACETONE		
BILE SALT		
BILE PIGMENT		
UROBILINOGEN	Noemal	
PUS CELLS	2-3	
EPITHELIAL CELLS	1-2	
RBC	NG/	
CASTS	AN)	
CRYSTALS	Nil	
OTHERS		
		

MICROBIOLOGY-CULTURE REPORTS

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









Every heart beat counts

Mr.KALIYAN S

71/Malc/MHI202381394

27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj

DIABETIC CHART

ACTUAL WE	EIGHT	6.3.kg	6.5.		
		MEDICATIONS	TAB- G	LYCOHET 6	1 0.5ml
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
27/12/23	1:36pm	130 mg/dL	<u> </u>	Das	Dr. praveo
	18.30	263 mg/dl	T. Glysomet ay ? Tex. H. M. BUR	20110	Dr. Prayeon
28/12	6-30	143 mg Tdl	NYO from 120	m Delto	DC000 16580
_					
			\		

INSTRUCTIONS FOR INSULIN INFUSIONS

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



0





DIABETIC CHART

Mr.KALIYAN S

71/Malc/MHI202381394

Pa 71/Mele/MHI202381394
Nt 27/12/2023/IPH2023002614
UI Dr.ANBARASU MOHANRAJ
DI

ACTUAL WE	EIGHT	<u> 6329</u> ньА,с	6.51.		
PREVIOUS	DIABETIC I	MEDICATIONS TAB. DILYLOR) .	-0-1 (BF)	
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
8 12 B	12-06	161 mg/dl	_	Alva Flo	Dr. proveen
	16-00	203 mg ldl	2mg-H-ACTOUPED		Dr-HEETHA
	18-00	171 mgidl	ey-H. Actrospid	-027003	DR-AJEETHD
	21:00	150 mybll	INFUSION STOPPED	Stoon	D3- PRIOVERIN
29/12/23	O6 ; 1 14	190 mg/dl	TAB. GIMUMET UP	By 10228	DR. PRAVASN JEGHEUM
	13:20	180 mg (22)		May 1007A	D1170VOU
	19-30	198 mg/dl	TAB. ULYOMET	gw 0270	DR. PROVEEN
30/12/23	06.00	155 maldl	J. GLYCOMST GPO. FM	1 /4/00X110CFT#	Drbravoon.
	12.30	287 mg/dl	IN. HAIOWH	Dor ve	1 AL
	18-0	208 ngfall	T. Orly consto	P1 @20:30	K MATINET)
31/12/2	6:30	209 mg (al)	Parent 68	1 NO 130	Som
		J	1 -	early oles	Dr. Praveen
		INSTRUCTIONS FO	OR INSULIN INFUS	•	

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







Every heart beat counts

T. GLYLCOMET GP2 1-0-0 7
T. ISTAMET SO/SOU 0-1-0 G BF

ACTUAL WEIGHT GALLONET QP. 0-0-1 JHDA,C. DOFT.

Mr.KALIYAN S 71/Malc/MHI202381394

27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ

PREVIOUS	DIABETIC I	MEDICATIONS	timetro process	1=0=10	B(1-)
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
11263	2.30	224 mg/d	Iù. HA - 120	Du 2	+ CARJUNOT
	18-30	III, nigldl	J-Glycomety P	AB 800 4.40	K. 973415359
1/1/24	6:30	182 mg/dl.	T. alycomet a	0.3 / 12 .00 00	Des 160m
	12-30	253 mg d	T. istamet holy	ing Mil	rol Dang
	18-30	97 meyloly	7. Glycome F. G	P, 80 819	· OSDILISM
2/1/23	6.30	131 mp/dl	1. Chilona at	P. P	Dog usn
	12.30	131 mg/dl 205 mg/dl	T. ISTARRY SO BOO.	3.00 foll	On:
-		0		·	
			X		
			·:		
		_			

INSTRUCTIONS FOR INSULIN INFUSIONS

*	Mix 40u short acting Insulin in 40 ml. of normal Saline (IU - 1 ml.)	BLOOD SUGAR mg / dl	INSULIN INFUSION
*	Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).	< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
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	hourly when stable) and adjust Insulin rate according to the following Algorithm.	201-250	Adjust Infusion rate to 4u / hr.
	5 5	251-300	Adjust Infusion rate to 6u / hr.
*	Target Blood Sugar 150-200 mgs.	301-350	Adjust Infusion rate to 8u / hr.
*	To monitor K+ separately.	351-400	Adjust Infusion rate to 10u / hr.
	Urine Acetone	>400	Adjust Infusion rate to 20u / hr.





Every heart beat counts

Mr.KALIYAN S

71/Malc/MHi202381394 11 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj



BLOOD GROUP

OTVE

INVESTIGATION SHEET

Date	20/12/3	28 12 13	29/12/23	30 12 33	11/24	
HAEMATOLOGY		-			,	-
Hb	14,7	13.2	13.0	12.4	<u> </u>	
P.C.V	43.8	39.0	38 b	· ·	36.5	·
Platelets	252000	173000	232000		218000	
TLC		· · · · · · · · · · · · · · · · · · ·	lagan	88330 .	-8870	_
Polymorphs			88,3	A CO	£2:4	
Lymphocytes	26.0		b17	data	エル	
Eosinophils	1.6		0.0.		1-4-4	
Mono / Basophils	R.4 0.4		219 0.1	100 for	50/05	
E.S.R	,,,		• •			
BIO-CHEMISTRY			•	-		
Urea	40		38	42	48.	
Creatinine	1.19		1.15	1.33	1.19	
Sodium	142			135	137	
Potassium	4.56			4.19	3.स	
Bicarbonate	24			,	_	
Chloride	102-1					
Magnesium	••	2.0	Ø~ 1			
Calcium						
Phosphorus	_					
LFT	*					
T.Bilirübin	0.18	<u> </u>	0.43	<u> </u>		
D,Bilirubin	D-08		•			1
I.Bilirubin	0.10					
S.G.O.T	14-0					
S.G.P.T	11.0			- "	•	
ALP	66					
GGT	21-0					
Total Protien	7.6					
S.Albumin	4-4		3.4			
CARDIAC ENZYMES	<i>'</i>					
Troponin I		<u> </u>				
CKNAC - CPK			વામ			
CK - M.B. MASS			14,2			
LDH						
Ntpro bnp						

-	0 1 1 0					1
Date	2012135		_			
COAGULATION	20/2/3-					
PT / INR	12.5 11.0		_			
Fibrinogen			_			-
D-Dimer APTT_	D 25-4					
LIPID PROFILE	ļ <u>.</u>		_			
Total Cholesterol						
Triglyceride		•				
H.D.L					•	
L.D.L						
V.L.D.V						
THYROID FUNCTION			_			'
T.S.H	3,96			· · ·		
T.3	111					
T.4	10.7		, F			
SEROLORY 2						
HIV			_			
	NEDIATIVE			-		
V.D.R.L			_			
COVID 19			 	•		
RT- PCR			_			
IgM			 -		,	
lg lg		1		1	•	J ,
HBA1C	6.5		_			
FBS/PPBS	6,2		_			
RBS			-			
S.AMYLASE				*		
S.LIPASE					•	
C.R.P						
PROCALCITONIN						
DDIMER			_			
S.Osmolality			_			
URINE						1
Osmolality			_			
Spot - Na	_ ;					
Spot - Na			_			
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Every heart beat counts

Mr.KALIYAN S

71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj

MAN TO THE REPORT OF THE PARTY
BLOOD GROUP

"0" positive

INVESTIGATION SHEET

Date	20/12/23		Ι			<u> </u>	
HAEMATOLOGY	20/12/				·		
Hb	4.7				٠		ľ
P.C.V	47.8			-			
Platelets	43.8 252000						
TLC	8860					-	
Polymorphs	66-6						
Lymphocytes	21-0			<u> </u>			
Eosinophils	1-6,			<u> </u>			
Mono / Basophils	5-4/04	_					
E.S.R							
BIO-CHEMISTRY							
Urea	40		_				
Creatinine	1.19		-				
Sodium	142						-
Potassium	4-56						
Bicarbonate	4-56 24			<u> </u>			
Chloride	102.1						
Magnesium							
Calcium				<u> </u>			
Phosphorus						-,-	
LFT							•
T.Bilirubin	0.18	<u> </u>					
D.Bilirubin	0.08						
I.Bilirubin	0.10		<u> </u>	<u> </u>			
S.G.O.T	14						
S.G.P.T	U						
ALP	66					_	
GGT	2)	ж. ь		<u> </u>			
Total Protien	7.6			<u> </u>		·	
S.Albumin	4.4					<u> </u>	
CARDIAC ENZYMES							
Troponin I	-			-			
CKNAC - CPK	_				_		
CK - M.B. MASS				 			-
LDH				+			ļ <u> —</u>
Ntpro bnp		<u> </u>	<u> </u>	<u> </u>		<u> </u>	

						_ ;
Date	20/12/23					
COAGULATION	1 1					
PT / INR	12.5/12.1/1.	<u>,</u>				
Fibrinogen	7					
D-Dimer apt	25-4					
LIPID PROFILE	7-					
Total Cholesterol						
Triglyceride						
H.D.L						
L.D.L					-	
VLDV						
THYROID FUNCTION						
T.S.H	3-96			•		
T.3	111					
T.4		-				
SEROLORY	10.7		 -			
HIV				-		
HBsAg	Man Roubic					
V.D.R.L	Inou Kenya					
COVID 19	 				<u> </u>	
RT- PCR						
IgM						
lg lg						
HBA1C	6.5					
FBS/PPBS	<u> </u>					
RBS						
S.AMYLASE	 					
S.LIPASE	 					
C.R.P				<u> </u>		
PROCALCITONIN	<u> </u>					
DDIMER						
S.Osmolality					 -	
URINE						
Osmolality	 				<u> </u>	
Spot - Na						
Opot - Na	 				 	
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Mr.KALIYAN S

71/Mule/MHI202381394 27/12/2023/iPH2023002614 MHI/IP/2022/066

Heart
Institute

Every heart beat counts

To: DE Date From: **Bed No: NTAKE & OUTPUT** 24 Hrs: Started Time: Ended Time: 그 **CHART** NPO Started at : NPO Over at: SHIFT Night Restricted Fluid (RF) Morning Afternoon 350MC. INTAKE ص OUTPUT 600 950m. Difference: Dogme. TA COMU **Total Output:** Total Intake: INTAKE (ml) OUTPUT (ml) Intravenous Infusion Tube N/G Drain Endorsed Time Oral រិទ្ធិន Total Time Urine **Vomitus** Others R/N Slan Feeding Type of Fluid Tube Additions **Aspirate** Amount bν 100 15.20 300 200 1430 150 20 19.00 600 200 10-00 7.00 750 CON 950 140 hoom 10:3 D00 353 4<0m 12 INTAKE TOTAL TOTA! ALCOUNT. BALANOE-Podmi



Mr.KALIYAN S
71/Malc/MHI202381394
27/12/2023/IPH2023002614
Dr.ANBARASU MOHANRAJ







Date	Fro	m: 30/12	d3	To	»: 31	les	کے Be	d No:(ಠ	4					INITAI	/F 0	OUT	DUT
24 Hr	rs : St	arted Time	: 7.13°	<u> </u>			Ended T	ime : 🦩	1 200)				INTA			PUI
NPO	Starte	ed at:	·				NP	O Over a	at:						CHA	'KI	
SHIF	T	N	lorning				Aftern	ioon			Nigh	t		Rest	ricted F	uid (RF	-)
INTA	KE						(up	_	<u> </u>	6	DONL					
OUT								740			<u> </u>	SOAL			- 2.40	ik (day	
Total	Intake:	15001					otal Outpu	t: 2 35	onl			Difference					
		1 = :	INTA		` 							OUT	PUT	(ml)		Т	_
Time	Oral	Tube		aven	ious I	nfusio	Amount	ioial	Time	Urine	Vomitus	N/G	Drain	Others	Total	R/N Sign	Endorsed by
		recuing	Type of Flu	ıa	Haai	itions	Amount					Aspirate	Tube				by
			Till	10.	30	ON	30 12 23										
							, ,	360ul							books		
11.00	150	<u> </u>						500	1230	200					800		
Blr	300		<u></u>					700	2 30	තුග					105D		
G.oo								880	162.05	SOD					1350		
B 30	0							Par	1 2 :50	1,5O					1500		
	200							1100	22,60	250					1750		,
93°00			,					1250	2:00	300					1050		
5:39	100							1350	5:30	300					2350		
62.50 62.50	150	7						1500									
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Mr.KALIYAN S 71/Mulc/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj







			_												
Date	Fro	m: 31/12	23 To	o: + 1 21	Be	d No: /	04 13		· · · · · · · · · · · · · · · · · · ·			INITAI			DUT
24 Hr	rs : Sta	arted Time	00:F.:		Ended T	ime : 🗷	~ ~ ~ O O					INTAI			PUI
NPO	Starte	ed at:			NP	O Over a	at:						CHA	ıΚΙ	
SHIF	T	N	Norning		Afterr	noon			Nigh	t			ricted F		
INTA	KE		300		30	О и.	0		G	60		<u> </u>	14 li	toes	ldan
OUTI	PUT	<u> </u>	100)			TO no			,	<u> </u>					ク
Total	Intake:	1/2	20		otal Outpu	it: 1530				Difference					
	,	· · ·	INTAKE							ַדַעס	PUT ((ml)			
Time	Oral	Tube		nous Infusio		[Total	Time	Urine	Vomitus	N/G	Drain	Others	ำัดเล	R/N Sign	Endorsed
		reeumg	Type of Fluid	Additions	Amount					Aspirate	Tube	Others		<u> </u>	by
8-30	250			<u> </u>		250	9-10	250					2:0		
[0:350	50					300	1140	280					280		
11-30	150					450	13-30	250					530		
12.00						ශාන	18.30		-				830		
14.20	ľ					6.00	_ -	350					1780		
16.40	1					700	2100	250					430		
19 40						E M	6,30	100					15 30	,	
21,00						950									
23;30						1050				Total	Drt	ake	- 40	om)	
						1150				Total		tout			
6,00	250					1400		-				lanie			
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				<u> </u>											



Mr.KALIYAN S 71/Malc/MHI202381394 27/12/2023/IPH202300261 Dr.ANBARASU MOHANRAJ





Date	Fro	m: @'ll	1/24 To	0: 2/1/2	д Ве	d No: t	14B					INITA	VE 0		'DUIT
24 Hr	s : St	arted Time	:निःञ		Ended T	ime ː;;	<u> </u>					INTA			וטץ
NPO	Start	ed at :			NP	O Over	at:						CHA	(KI	
SHIF	Т	N	lorning		Afterr	ioon			Nigh	t			ricted F		
INTA	KE		<u> 500</u>		3	50 ml			250mc	-		್ನ	Achit	resid	œu
OUTF			550		<u>`</u>	Doml	,		ZOMC.						<u> </u>
Total I	ntake	: [[pomc_		Total Outpu	it: 16	DOM	-		Differen		<u>100Z.</u>	ML		
		- 	INTAKE			·				OUT	PUT	<u>(ml)</u>	1		•
Time	Oral	Tube		nous Infusio	,	Total	Time	Urine	Vomitus	N/G	Drain	Others	'ilotal	R/N Sign	Endorsed
		recuity	Type of Fluid	Additions	Amount					Aspirate	Tube	-	Jotal		by
7.00	101					100	25.30	150					(ZQ		
8.50	121					250	10.00	300					450		
S S	-	1				_	11.30	1					520		
11-30							14.00						750		
13.Yo						600	1	300					loso		
A -00					-		92.00						1.350		
700						800	11.00	_					1600		
[৪৪০						850	 	<u> </u>					1000		
20.3			,	<u> </u>		920									
20	•	1				1000									
6.2		1				1100	,	-	78	TAC	INT	ACE	- 116	10	
	- 1 50					\\ \ <u>\</u>			•	TAL	00-11		1600		
				1							7.4	101=			Naa.
		<u> </u>								 		1	2001	13	024

Mr.KALIYAN S



71/Malc/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj





Date	Fro			D:3 1 2	Be پئ	d No:	1011-7	3/_				INTAI	ν Ε 2	ОПТ	DIIT
24 Hrs	s : St	arted Time	00.4-	<u>.</u>	Ended Ti	ime : 🚡	£.00					IIVIA			ונטק
NPO S	Starte	ed at :			NP	O Over a	at:						CHA	KI	
SHIFT	• [M	lorning		Aftern	oon			Nigh	t		Rest	ricted F	luid (R	F) _
INTAK	Œ	51	o aul.									P.F	1 H C	i teno	day
OUTP	UT	&0	o mil									\		•	, d
Total Ir	ntake:				otal Outpu	ıt:				Differen	ce:				
			INTAKE	(ml)						OUT	PUT	(ml)			
Time	Oral	Tube		ous Infusio	n	Total	Time	Urine	Vomitus	N/G	Drain	Others	Trackii	D/M Sign	Endorsed
		Feeding	Type of Fluid	Additions	Amount	[OIGI	Tillie	Offile	VOIIIILUS	Aspirate	Tube	Others	norens.	Nit Sign	- by
720	200					200	7-30	300					300		
1-46		1				450	11-46	30 <i>(</i>)					600		
00-10						550									
11 ×00	<u> C</u>			-		-51-510									
		<u></u>								Tota	9 In	take-	22	m/	
										Total	J 6	et put.	600	m ,	
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(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.KALIYAN S

71/Malc/MHI202381394

27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ



VITAL INFORMATION SHEET

MHI/IP/2022/074

Medway
Heart
In stitute

Every heart beat counts

BLOOD GROUP D' DORITIVI
ON ADMISSION
Height in CM Weight in Kg.

162 cm 63 kg.

Diagnosis:	(AD	~	7	V	0														ı	Pro	ce	dur	e :																L						<i>-</i>	` `]				Reg	ł		
NO. OF DAYS		Po					y <u>-</u>																																															
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AP Stoppedon 23 /12/23



BLOOD GROUP

Every heart beat, counts

POSITIV

Medway Hospitals®

The way to better health

Mr.KALIYAN S

P; 71/Male/MHI202381394

27/12/2023/IPH2023002614

U Dr.Anbarasu mohanraj

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ON ADMISSIÓN **VITAL INFORMATION SHEET** Height in CM Weight in Kg. opeas x 8 deats llaum 63Kgs Procedure: מתמ

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Mr.KALIYAN S
71/Male/MHI202381394
27/12/2023/IPH2023002614
Dr.ANBARASU MOHANRAJ

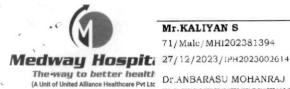


Every heart beat counts

EARLY WARNING SCORE MONITORING CHART

NEWS have	DATE	163/	13/11	3/11/		- Mr	21/12/	12.100	11/2	MIL	11/2	1112	. 1.1	24.11	DATE
NEWS key 1 2 3	DATE	901	0 0	ויכ	31/12	311	31110	11115	11,	11.1	111	11.	711	21117	DATE
	TIME	19 22	1 60	10.00	11.00	48/	2210	Pia	10.00	14.60	1,8100	22.00	6.00	10.00	TIME
B	>25		1000		14	The same	TO SECOND	3		11		MERCHAN			>25
espirations	21-24							2							21-24
eath/ min	18-20	-0	10	ac	0	_	-0				-	-		-	18-20
	15-17	-0	-		_										15-17
	12-14							4							9-11
	9-11		-					1	-	-	-	-	-		<8
+B	<8 >96			5	70	- 1		3	→ _		-				>96
o2 Scale 1	94-95	0			-			1			-				94-95
cygen Saturation (%)	92-93		10000					2							92-93
	<91		12 55 5	-		10000	2000	3		10000	1000	-		700	<91
oo2 scale 2 oxygen sturation (%) use scale 2 target range is 88-92 % to in hypercapnic piratory failure only	>96 on oxygen							3							>96 on oxygen
scale 2 under the	95-96 on o2							2							95-96 on o2
rection of qualified	93-94 on O2							1							93-94 on O2
nician	>93 on air														>93 on air
	88-92													-	88-92
	86-87							1							86-87
	84-85							2							84-85
	<83%														<83%
r or Oxygen ?	A= Air	-0	-	w	~		7	-,	-		-	-	-	-	A= Air
	O2litre/ min		I HARD					2		-					O2litre/ min
	Device														Device
ood Pressure	>220							3							>220
	201-219														201-219
	181-200							2							181-200
	161-180														161-180
	141-160														141-160
	121-140	0	-	1	-							-		-	121-140.
	111-120							_	-	Q	1.				111-120
	91-100							1							91-100
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	<50	000000	4000					2							<50
stolic BP	mmHg	Oto	70	80	62		70	00	8/2	82	Pu	95	80	00	mmHg
Stolic DF	>131	30	-10	0	02	Name of Street	40	3	100	0.1	-	0	0	01	>131
Ise	121-130							2							121-130
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nfusion	P	-				Property Services		3		•					P
o score if chronic)	U		9 00 00 00	1000				3							U
	>39.1 degree	THE PERSON	-					2	-						>39.1 degree Celsius
	Celsius			1	1000										-Breading
mperature	38.1-39.0							1							38.1-39.0
gree Celsius	37.1-38.0										-				37.1-38.0
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EWS Total onitoring Frequency calation of Care Y/N itials by RN itials by Sr. RN		Jan Jan	1 APRY	(A)	No f	04	Hey	1 Day	001	7	NB	2	10	28	/

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



Mr.KALIYAN S

71/Malc/MHI202381394

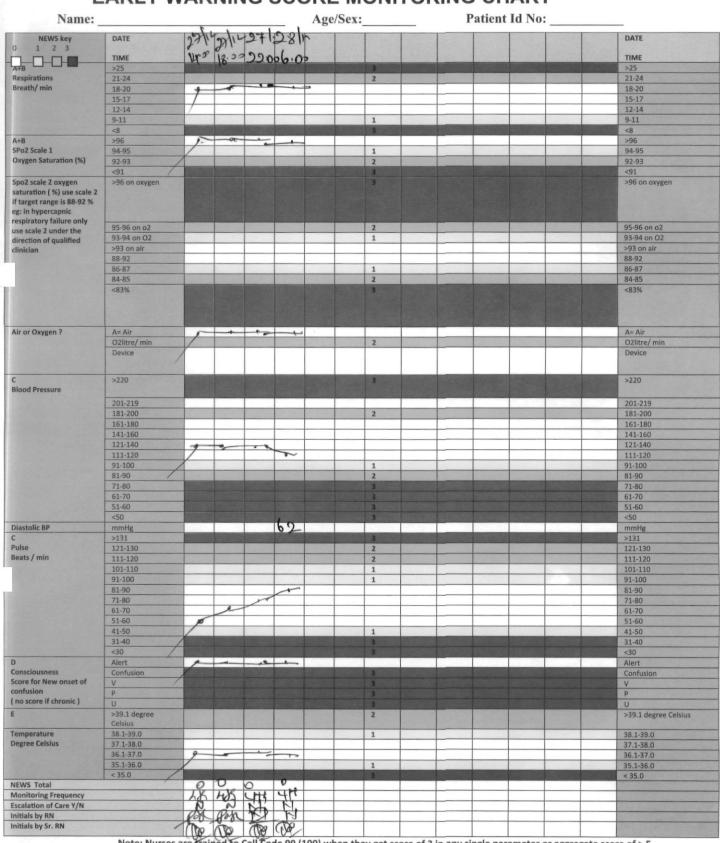
Dr.ANBARASU MOHANRAJ





Every heart beat counts

EARLY WARNING SCORE MONITORING CHART



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	4	Every Hourly	
frequency	3	Every 2 nd Hourly	
	2	Every 4th Hourly	







Every heart beat counts

1	Mr.KALIYAN S
į	71/Malc/MHI202381394
i	27/12/2023/IPH2023002614
1	Dr.Anbarasu Mohanraj
1	

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

osis: CADO	-WD	EF-60./.	laruma	Opli	gì <i>d</i> uu	ià 1 c	BRU	· _
t:	ms -	Weight:Kgs	Food allergie	s: Yes/ Nor If y	s, specify			
onz pelisiz:	-	J vegetarian	Non vege	etarian ,		☐ Egge	tarian	☐ Jain
rescription:	000	catein, lo	10d b	s Jour	, ligh	L Du	. Tulle	diabetur al
JECTIVE	GLOB/	AL ASSESSMEN	T (ADJULTS)		' /	1		
		<u> </u>		,				
	(A) -	Patient's related Medical His						
	1)	Weight Change (overall chan			<u>· </u>		. 1	
		<u></u>	□2 					□ 5 ————————————————————————————————————
	e	No weight change/ gain	<5%	5 - 10%	•	10 - 15%		>15X
2)	Dietary Intake	Duradop					_	
·		<u> </u>	□ 2	<u></u> 3		- Q 4		□ s
•	Oral .	No change	Sub - optimal solid diet	Full liquid die moderate overall decre		Hypo - ci liquid dis		Stanvation
	Enteral / Parenteral Nutrition	Adequate/ Excessive	Sub - optimal	Inadequate		Typo-ca feeds	loric	Stanyation
3)	Gastrointesti	nal Symptome Duration:						
		121 ·	□ 2	□ 3				
	~	No symptoms	Nausea	Vorniting / moderate GI symptoms		Diarrhoe		severe anorexia
4)	Functional C	apacity (Nutrition related functional in	npairment) Duration:		•			
	·	101	1 2	□3			, <u> </u>	□ s
		None /Improved	Difficulty with ambulation	Dimenit normal :		Light	activity	Bed / chair - ridden with no or little activity
5)	Co - morbidity	(Disease and its relationship to nutriti	lon requirements)		-			
		[] 1 ·	2	3				<u> </u>
	_	Healthy	Mild co - morbidity	mor	erate co - bidity/ age years		ere co- foldity	Very savers multiple co - morbidity
B)	Physical exar	nination		<u> </u>				•
1)	Decreased fai	stores or loss of subcutaneous fat					,	
		121	2		-			<u> </u>
		Normal	Mild	Moderate				Severe
2)	Sign of muscle	wasting						
	ے	EII.	□ 2				<u>. </u>	□ 5
		Normal	Mild	Moderate			<u> </u>	, Severa
Total Score = Su	m f above 7 com	ponents						
Nutritional State	is : Based on this	patient is	- <u></u>					
	Well Nourished			Ø17 to 14)				-
	Moderately Ma			(15 to 18)	- 11c		 -	_
	Severely Malno	urished		[19 to 35]	<u></u>	<u> </u>		
Nutrition Interve	endon;							·
	Q eni			☐ Enteral		☐ Parenteral		
Diet counselling	provided:	Yes		□ No				
Frequency of re-	assessment:	Weekly			☐ Fort - night		☐ Monthly	
Enteral / Parente	eral	□ Daily			Caforle count:	☐ Yes	No	

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
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	be used wounded on suidust my	
·	Kleb TUD/DU/HED/Dyslipidumia. Educated the patient and family	
-	on 1600 caloin, or fat, by rout, high	
	publin, diabeter dit. Expfid en Snaer fort mean & low grennin wilned	Maria Catherin Ster Pr 1. Senior Dietitian
28/12/4, 16:00	Patriot Septed to OT for surgery CARRY and kept on MOH. Patriot wind to St	
	will initiate on deadsite, Gind dut as per do Aris adin.	Name Catherine Colory, Senior Distillar
29/14h, 10200	how one. Patient benated diabete, indid dit. Cape initiate a diabete high public, soft solid dit.	Moria Catherine (201) Senior Diction
13:10 70/10pr	Patuit juid & word- Reenpfid on chit vishicher. Motrated bear wer.	0.50



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

Mr.KALIYAN S 71/Malc/MHI202381394 27/12/2023/IPH2023002614 Dr.ANBARASU MOHANRAJ

MHI/DIET/2022/148 Every heart beat counts

Department of Dietetics

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	CARE PLAN FORM - A	- 33.65511 89AU -
DATE AND TIME	DIETITIAN NOTES	SIGNATURE
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- INTERAOPERATIVE NURSING RECORD

Mr.KALIYAN S 71/Male/MHI202381394 27/12/2023/IPH2023002614 Dr.ANBARASU MOHANRAJ	RAOPERATIVE NURSING RECORD
1	Consultant: Dr. Ar
1	Date of Surgery: 28 12
Mode of Transfer to OR	□ Bed □ Stretcher □ Other □
Anaesthesia Type	: Epidural Spiral LOC MAC
•	GEN Regional
Position	: Lithotomy Prone Supine Right Down Left down
4.	□ Lateral □ Other □
Pressure Protection Pad	: Headrest Sand Bag Pitlow Axillary roll
•	Axillary foll
	☐ Shoulder roll ☐ Eye protection ☐ Chest roll ☐ Cysto/Gyn ☐ Sling ☐ Boot ☐ Stirrups/Leg Holder
	L aem rest padded / Sccured R Arms tucked / padded
Skin preparation in OT	Collection Council (Speeding)
propulation in O 1	
Electrocautery	Alcohol Prep United Specify) : Monopolar Pad Loacation Bipolar
Tourniquet	Location Bipolar
	Applied Time
	Applied Time
Other equipment used	Applied Time Released Time
	·
i cisonai	☐ Surgeon — ☐ Asst. — ☐ ☐ Asst. — ☐ Asst. — ☐ Asst. — ☐ Asst. — ☐ Asst. — ☐ Asst. — ☐ Asst. — ☐ Asst. — ☐ Asst. — ☐ Asst. — ☐ Asst. — ☐ Asst. — ☐ Asst. — ☐ Asst. — ☐ ☐ Asst. — ☐ ☐ Asst. — ☐ ☐ Asst. — ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
	Anaesthetist - Asst. Ass
Type of Specimen	
Lab	: Pathology Permanent Frozen Time sent
	Cytology Time of report
	☐ Microbiology
	☐ Biochemistry .

Packing / Drains / Catheters

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Date & Time			(



Mr.KALIYAN S re) 27/12/2023/IPH2023002614 Dr.Anbarasu mohanraj

PSYCHOLOGICAL WELLBEING REPORT

Date: 02/01/24

Time: 12.20 pm

Unit: 104B

Clinical diagnosis:

Surgery/Procedure: OPCABX 8 graph 172 DM - Pod V

Impression: Functioning well, number decline.

-colm affect, overted, rommin.
- orleep 3 appelite 0

- no prychological distres reported.

Employee ID: MH (0275/084

Signature of the Psychologist:





Mr.KALIYAN S 71/Male/MHi202381394 27/12/2023/IPH2023002614 Dr.ANBARASU MOHANRAJ

Dr.Anbarasu mohanraj



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NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission: 17 19 2 Time of Arrival: 12 -30 Mode of Admission: Walking Wheelchair Stretcher							
Accompanied by Relative: Yes No If Yes, Name of the Relative: Ml. Ol. Saravalia.							
Relationship with Patient: father Contact Person's Name: Us Squarcus Relationship: fatherein Lau							
Contact No.: 9486659113 Primary language spoken: I Tamil/ English Indian International							
Interpreter needed: Yes No /							
Patient status: Conscious Unconscious Disoriented Patient Vulnerable: Yes No							
Menstrual History: LMP: Menopause:							
Medical History: DM/HTN/Co-Morbility: 15 yeary Yes If yes specify Drugs History: Antiplatelet Tale valary (Specify) Themestale, Tale Elegation One 33 1923							
Psychological Status: Anxious Withdrawn Agitated Depressed Sleeping Difficulty							
Do you have any special religious, spiritual or cultural needs to be considered? Yes No							
If Yes, specify details:							
Socio Economic Status: Employed Retired Own Business Home-Maker Others:							
Vital Signs: Temp: 16 (°F) Pulse / HR: 60 (beats/min) BP: 130 70 (mmHg)							
Respiration: 20 (breaths/min) SpO ₂ : 98 (%) CBG: 130 (mg/dl) Height: 162 (cms) Weight: 63 (kgs)							
Allergies / Adverse Reaction: Yes No Medication Blood Transfusion Food Mot known							
If Yes, specify:							
Pain: Yes No. If Yes, Score: 6 Pain Scale Used: Wong-Baker FACES Pain Rating Scale (7-12 years)							
Numerical Rating Scale (>12 years) CPOT (ventilator / comatose)							
Duration: Location:							
Pain Character: Dodf 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: Decebetic deat							
Dietician Informed: Yes No. If Yes, mention the Name: Caller Time: Time: Time: Time: Time: Time: Time:							
Orient Patient if: Conscious Orient Patient Attendant if: Unconscious Disoriented							
Boom Side Rails Toilet Bell Patient Information Board Bathroom Bed Controls							
Use of Footstool Grab Bars Nurses Call Bell Television Light Controls Telephone							
Functional Assessment:							
Particular Assessment Remarks Outcome							
Visual Impairment Yes No							
Hearing Impairment Yes No							
Chewing Difficulty							
Walking Difficulty Yes No							

DVT RISK ASSESSMENT Assign a score of 1 if (YES) in parameter nos. 1 to 9, and assign a score of -2 if (YES) in parameter no. 10 S. No. **Parameters** Yes / No Score Active cancer (on-going treatment or diagnosed within 6 months or palliative care) Yes Мб 2 Bedridden recently >3 days or major surgery within four weeks Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle Yes No 3 (Assess for both legs) Yes 🗸 4 Collateral (nonvaricose) superficial veins present (Assess for both legs) Entire leg swollen (Assess for both legs) Yes 5 6 Localized tenderness along the deep venous system (Assess for both legs) - No Pitting edema, greater in the symptomatic leg (Assess for both legs) 7 Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs) 8 9 Previously documented DVT (Assess for both legs) Yes 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) Yes No oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture. Risk Score Interpretation (Probability of DVT): Final Score Tick the score obtained (\checkmark) Action Taken Date Time Low Risk -2 to 0 **Moderate Risk** 1 to 2 **High Risk** 3 to 8 Personal Belongings / Valuables: Name & Signature of the With Patient's With **Valuables** Description Remarks Patient / Patient's Attendant Attendant **Patient** □Upper □ Lower **Dentures** □Both □Nil) □Right □Left **Hearing Aid** Ø₩ii Eye glasses / □No □ Yes **Contact lens** Jewellery ☐ Yes □ Nter Other valuables (specify) **Report** (List of X-ray, ECG, lab reports retained with the nurse): Sign Name Emp. No. Date Time Patient / Relationship **Patient's Attendant** Nurse 000 X Unit In-Charge





Mr.KALIYAN S 71/Malc/MHI202381394 27/12/2023/IPH2023002614 Dr.Anbarasu mohanraj



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PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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Date: 2	# 12	2-3 Shift: Morn	ing Devening N	light	•			
S	Ventilator Periphera Ryle's Tul Urinary C	S: (A) - (TV). PEWS Score: day: Il line day: Right: Left be:		GCS: 15 POD: Central line of VIP Score: (015			
В		urgery: if any: WJLDA	pour cui	Date of surge				
A	ASSESSMENT Vital Signs: Temp. CF - (CF) Pulse / HR: (beats/min) Respiration: (breaths/min) BP: (Dreaths/min) SpO_2: (Sp) Height: (Cms) Weight: (Kgs) BMI:							
R	Referral of Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: nstructions if any:	□No. If Yes, modified	care plan date	T/4			
11		Signature	Name		Emp. No.	Date	Time	
Handover to		Slefe	U.Lid	eijci	0244	27/12	10,3	
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Date & Time	(Observations / Action		Signature with E	mp. No.
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Mr.KALIYAN S

71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj



Every heart beat counts

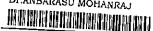
PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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Date:	27/12	Shift: Morn	ning □Evening Night ' '	* 1.		
S	Ventilator Periphera Ryle's Tul Urinary C	s: A - I M TV PEWS Score: — day: Il line day: Right: — Left be:	POD: — Central line of the contract of the con	days:		
В	On room				.1 - 1 .	
A	BP: 12 Others: Pain Sco Fall Risk Braden S	re: OhoPain Scale used Score: Minimal Risk: 23-19 Ulcer Scale for Healing (PUS	/ HR:(beats/min) Respira (%) Height:(cms) Weight: : PIPPS / CRIES / FLACC / Wong-Bak ptocol: Low MediumHigh At Risk-Mild Risk: 18-15 Moderate Risk SH):Yes No NA	ker FACES Pain Ratin sk: 14-13 High Risk: Dressing done: Yes	DILON g Scale / NAR 12-10 □ Severe	
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:	Nill No. If Yes, modified care plan date YOW Plan CABO	<u> </u>	· .	
		Signature	Name	Emp. No.	Date	Time
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NURSES PROGRESS NOTES								
Date & Time		Observations / Action	!	Signature with Er	np. No.			
27/12/23	Night	duty Notas			• .			
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Mr.KALIYAN S 71/Malc/MHI202381394

27/12/2023/IPH2023002614 Dr.Anbarasu mohanraj



/IHI/NUR/2022/048



	Ni	JRSES PROGRESS NOTES		
Date & Time	· · · · · · · · · · · · · · · · · · ·	Observations / Action		Signature with Emp No.
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<u> </u>	Patient Posted For Procedu	rice: CABN		duristy
	Under Anesthesia:			
	Olider / thesinesia:	noral Anaethoeta	_	0036
	Allergy Status: NYLD	А		
	Known Case Of: Type:	II DM, SHTW. DYBLIPIDG	mra	
	Past Surgical History: 0	1 cataract extraction	<u>ομ</u>	
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	Pacing wire placement: Pro			
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	Cautery burn/skin peeling/	towel clip mark: Present/Absent		000
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Mr.KALIYAN S 71/Male/MHI202381394 27/12/2023/iPH2023002614





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: D8/10/23 Shift: Morning Evening Vight								
S	NEWS / F Ventilator Periphera Ryle's Tu Urinary C	S: CAD-TVD SF36 PEWS Score: - day: - I line day: Right: NSTACPF be: Yes No Day catheter: Yes No Day		GCS: 15/15 POD: DOS Central line d VIP Score:	$\mathbb{D}(\mathcal{S})$			
В	Allergies On room	ROUND urgery: OPCAB X & & if any: NCDA air / oxygen: On North uts / New Symptoms in last s	al protys. 1	Date of surge	ny: 28/12/23 nw: KABILYTE			
A	ASSESSMENT Vital Signs: Temp: 18 (°F) Pulse / HR: 85 (beats/min) Respiration: 18 (breaths/min) BP: 158 + 1611 mmHg) SpO ₂ : 100 (%) Height: 162 (cms) Weight: 18 (kgs) BMI: 24, 0 Fg m². Others: CNP > 9 mmHg, B&A > 168 m² Pain Score: 10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: 50 Fall Risk Protocol: Low Medium 4 figh 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 07 Current diet: Faud diet Pressure Location Research Risk: 14-13 Risk Risk: 14-13 Risk Risk: 14-14 Risk: 14-15 Risk:							
R	Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Tyes follow-up orders: mstructions if any:		are plan date:	,			
Handover g	iven by	Signature	Name		Emp. No.	Date	Time	
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	NURSES PROGRESS NOTES				, , ,	
Date & Time	Observations / Action			Signature with Emp. No.		
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	harmodynamically stable Condition					
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	felt.				<u>~</u>	
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<u> </u>	* Due to pain Complainte Site	erku	1			
	Intruios 25 mille started as por doctora	dur	522	<u> </u>		
33;4€D	* Due to ABP > 199/100 mitty. Timote					
29/10/23	25 mg Plo given as par Dr. pravon advis	ره.	SH SH	<u> </u>		
Q0100	4 -App -> 145/80 molty		<u> </u>		-	
01700	- Due to busine output shi-law long of	inen	2 4			
03100	* patient is in hoomodynamically					
	stable Condition			. 1		
04!30	Blood Investigation send as pe	290		22 2	-	
	protocol, Nebulization given			2.41		
05:30	- Bed both provided & oral Gre		4			
	girch.			2.11		
<u>02720</u>	well.			60 hrs		
06200	* U-Coth Cace give					
06:10	* Spirometry Explained & patient	4	L	11		
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	done.		ত	[]		
06:15	a ABU done.					
DF! 20	* patient hardonered to next		5	Sull		
	duty statt in harmodynamically state	deCon	Atron	5 oky		
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Document endorsed by	Dinera'	00	25	30/1423	9,00	





Mr. KALIYAN S Nan 71/Male/MH1202381394 UHII 27/12/2023/IPH2023002614 DOB DOA Dr. ANBARASU MOHANRAJ



PATIENT CLINICAL HANDOVER RECORD: FOR NURSES

Date: 12.8	112/03	Shift: Mor	ning Evening Night	· · · · · · · · · · · · · · · ·	· 10			
S	SITUATION Diagnosis: CAD TVD NEWS / PEWS Score: Ventilator day: D							
В	Type of s Allergies On room	ROUND surgery: OP CHB X 3 UR if any: N D H air / oxygen: D N VEN nts / New Symptoms in last s	1 (IV fluids on t		to Strong nagy to Strong Nagy			
A	ASSESSMENT Vital Signs: Temp. 177. (°F) Pulse / HR:							
(Referral Pending	MMENDATION doctors: medications: medication indent:	7 Mir		Trans.			
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		- 3	D Sheeba	0270	28/12/2 18:30			
Handover t	aken by	Coule	SUGANYA-Ce	0223	281223 19:30			
Document (endorsed	W /	din me	t Occept	29/14/2 9,00			

NURSES PROGRESS NOTES							
Date & Time	Observations / Action		Signa	ure w	mpi No.		
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Mr.BALASUBRAMANI

62/Male/MHI202381326 , 27/12/2023/IPH2023002613

Dr.RAJESH.V





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date:	a 12 23	Shift: Morr	ing Evening Night			•
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CAD ~ JVD PEWS Score: — day: — Il line day: Right: Ma Caef be:	에 P2 :	00 ne days: D 2 වෙර(ර		
В	Allergies On room	ROUND urgery: OPCAB if any: NK OA air / oxygen: nts / New Symptoms in last s	!V fluids o	urgery: &8 12 23		
A	Others: Pain Sco Fall Risk Braden S Pressure	re: 10 Pain Scale used Score: 50 Fall Risk Pro	: PIPPS / CRIES / FLACC / Wong- ptocol:	ht: <u>63</u> (kgs) BMI:_ Baker FACES Pain Ratir	ng Scale / JUR 12-10 Sever I No NA	; e Risk: 9-6
R	Referral of Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:	☑No. If Yes, modified care plan o	late:		
		Signature	Name	Emp. No.	Date	Time
Handover given by		Orania.	CONTA FLORAGE'S	00 F/4	29/12/23	19.30
Handover t		2	D-sheeba	0270	29 12/1	19.40
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	NURSES PROGRESS NOTES									
Date & Time		Observations / Action		Signa	ture with E	mp. No.				
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	Mr.KALIYAN S
Pa	71/Malc/MHI202381394
Na	27/12/2023/IPH2023002614
UH	
DO	Dr.ANBARASU MOHANRAJ
DO.	
	113 Mil 1441 Mil 144



	PALIE	INI CLINICAL F	IANDOVEN N	ECOND FON NON	ISES				
Date:	19/12/	Shift: Morn	ning Evening N	ight ·					
S	Ventilator Periphera Ryle's Tul Urinary C	s: CAD TVD PEWS Score: day: day: Il line day: Right: MODE Left be: Yes No Day atheter: Yes No Day	: D 2	GCS: POD: POD -1 Central line days: D2 VIP Score: 0[5					
В	Allergies On room	ROUND urgery: OP CHB X 3 C if any: NCD H air / oxygen: QN PCH ats / New Symptoms in last s	ı	Date of surgery: 28/12-63					
A	ASSESSMENT Vital Signs: Temp: 9 Pilse / HR: 20 (beats/min) Respiration (breaths/min) BP: 20 Mm (minHg) Sp0; 93 / (%) Height: 60 (cms) Weight: 60 (kgs) BMI: 24 19 / m Others: 80 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale NRS / CPOT Fall Risk Score: Fall Risk Protocol: 10 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: 20 Main Vest No NA Course Vest No NA Drains:								
R	Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:	J. Miles	are plan date:		3.5			
		Signature	Name	Emp. No.	Date	Time			
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NURSES PROGRESS NOTES								
Date & Time		Observations / Action		Signat	ture with E	mp. No.		
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29/10			· · · · · · · · · · · · · · · · · · ·					
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| Mr.KALIYAN S | 71/Malc/MHI202381394 | 27/12/2023/IPH2023002614 | Dr.ANBARASU MOHANRAJ



Date: 30 12	30 ∫12 23 Shift: ☐ Morning ☐ Evening ☐ Night								
S	NEWS / P Ventilator Periphera Ryle's Tut Urinary C	s: CAD~IVD PEWS Score: — day: — al line day: Right Volver polet be:	₩IJვ /:_ ^ VIP	S: 15(15) DD: W PC ntral line da P Score: 0 ify organism	PA				
В	Allergies i On room	ROUND urgery: OPCAB if any: NKDA air / oxygen: nts / New Symptoms in last s	IV fi	te of surgery	y:28/12/23 n: —	:			
A	ASSESSMENT Vital Signs: Temp.9 7 7 7 P Pulse / HR: 96 (beats/min) Respiration: 23 (breaths/min) BP: 165 7 6 (mmHg) SpO ₂ : 91 (%) Height: 62 (cms) Weight: 62 (kgs) BMI: 4 6 m Others: 880 1680 Pain Score: 1680 Pain Score: 350 Fall Risk Protocol: Low Medium High Braden Score: Minimal Risk: 23-:9 At Risk-Mild Risk: 18-15 Moderate Risk: 14-13 High Risk: 12-10 Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): Yes No No No No No Drains: Rational Risk: 12-10 No No No No No No No No No No No No No								
R	Pending Pendin	medications: medication indent: lab reports / Investigations: alue alert and its corrections	No. If Yes, modified care		12 A				
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	NURSES PROGRESS NOTES							
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71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj



Date: 34	Date: 30 しゅ (03 Shift: Morning Evening Night									
S	SITUATION Diagnosis: GCS: NEWS / PEWS Score: Ventilator day: Peripheral fine day: Right: Ryle's Tube: Yes No Day: Urinary Catheter: Yes No Day: Barrier nursing: Yes No MDR: Yes No. If Yes, specify organism:									
В	Allergies On room	round urgery: opcan x b if any: 100 t Anoc air / oxygen: on 200 ats / New Symptoms in last s	on m w v	Date of surg	ery: 28/12/27 ow: ー					
A	ASSESSMENT Vital Signs: Temp:(8 F) Pulse / HR:									
R	RECOMMENDATION Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: Critical value alert and its corrections: Changes in nursing care plan: Yes No If Yes, modified care plan date: Pending follow-up orders: Special instructions if any:									
Handover g	given by	Signature	Name	h 9-	Emp. No.	Date 36/12/2	Time			
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NURSES PROGRESS NOTES							
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Mr.KALIYAN S 71/Male/MHI202381394 27/12/2023/1PH2023002614 Dr.ANBARASU MOHANRAJ



Date: 2	0 12/23	Shift: Morn	ing ☑Evening ☑Nigh	it .	•				
S	Ventilator Periphera Ryle's Tul	s: AP TY DEWS Score: O day: I line day: Right: Left De: Yes No Day atheter: Yes No Day	PO Cei	S: 5 15 DD: 15 ntral line da Score: 0, ify organism	ls · ·				
В	Allergies On room	ROUND urgery: DP LAB XS (if any: NKDA air / oxygen: On XOOO ts / New Symptoms in last sl	naer Iva	te of surgel	ry: 28/12/23. w:_) 		
A	ASSESSMENT Vital Signs: Temp: 98.9°F) Pulse / HR:								
R	Referral of Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:		plan date:					
		Signature	Name		Emp. No.	Date	Time		
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NURSES PROGRESS NOTES									
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71/Malc/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ





PATIENT CLINICAL HANDOVER RECORD FOR NORSES									
Date: 3개	12/23	Shift: Morn	ing Evening Night	•					
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CHD - TUD PEWS Score: () day: () Il line day: Right: () be: () Yes () No Day atheter: () Yes () No Day	: VIP Score	e days: — : 015					
В	Allergies On room	ROUND urgery: OPCADX 3 9 99 if any: NOOO air / oxygen: On Y OOM Cots / New Symptoms in last st	NV IV fluids or	rgery: 28(12년) flow: —					
A	ASSESSMENT Vital Signs: Temp: 98-6°F) Pulse / HR: 4 (beats/min) Respiration: 90h (breaths/min) BP: 110 40 (mmHg) SpO ₂ : 94 (%) Height: 162 (cms) Weight: 63 (kgs) BMI: 24 (cms)								
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 Ne-ff Yes, modified care plan date: Pending follow-up orders: Special instructions if any:								
		Signature	Name	Emp. No.	Date	Time			
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Mr.KALIYAN S 71/Malc/MHI202381394 27/12/2023/IPH2023002614 Dr.Anbarasu mohanraj



DATIENT OF INCOME

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	PAHE	INT CLINICAL,	IANDOVER REC	OND FOR NOT	IJLJ		
Date: 30	112/2	Shift: Morr	ning Evening Night		•		
S	NEWS / P Ventilator Periphera Ryle's Tut Urinary C	S: CAD -TVD PEWS Score: O day: I line day: Right: Lef De: Yes No Day atheter: Yes No Day	POD: Centr t:	al line days:	•	.`	
В	Allergies i	ROUND urgery: のpGNBよるり if any: NBDB air / oxygen: ひょ しの its / New Symptoms in last s	m aer_ IV flui	of surgery: 28 12 3	2-}	`,	
A	ASSESSMENT Vital Signs: Temp: 97-60°F) Pulse / HR:						
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections	nùl: ∷ □No. If Yes, modified care pl	an date:			
		Signature	Name	Emp. No.	Date	Time	
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16-00	provided to Sleep.	Clean Calus ce	ied)	
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Document	Signature	Name C. Nalini	Emp. No.	Date Time 3.1 (2.12.3 do.) 00
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Mr.KALIYAN S 71/Malc/MHI202381394

71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj



Date: 31	12/23	Shift: Morr	ning ⊡Evening ☑ Night			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: PD - IV PEWS Score: O day: day: al line day: Right: Lef be: Yes No Day eatheter: Yes No Day	Cer V: VIF	S: 15 15 D11 Stral line days: Score: 0 15 ly organism:		
В	Allergies On room	ROUND urgery: OF CHE X3 if any: NEDH air / oxygen: Sh 800 M ats / New Symptoms in last s	ر منلا ۱۷ ا	e of surgery: QQ (12/28 uids on flow:		
A	BP: \(\)\(\)\(\)\(\) Others: Pain Sco Fall Risk Braden S Pressure	ns: Temp: <u>9</u>	(%) Height: 162 (cms) I: PIPPS / CRIES / FLACC / Votocol:	Respiration: 20 (breat) Weight: 43 (kgs) BMI Wong-Baker FACES Pain Ration High Description of the content of the c	DHRg/m ng Scale / NR: 12-10∐Seven	S / CPOT
R	Referral of Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections	No. If Yes, modified care	plan date:		
		Signature	Name	Emp. No.	Date	Time
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Date & Time		Observations / Action		Signature with Emp	o. No.
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Mr.KALIYAN S

71/Malc/MHI202381394 27/12/2023/IPH2023002614

ĐĐ Dr.Anbarasu mohanraj





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PATIENT CLINICAL HANDOVER RECORD FOR NURSES							
Date: 01)6	1/24	Shift: Morn	ing Evening 🗀 t	Night		•	_
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	S: CAD_TVD PEWS Score: 6 day: ~ Il line day: Right: ~ Left be:		GCS: _/ POD: ப்ப Central line o VIP Score:ව pecify organis	days: -		
В	Allergies i On room	ROUND urgery: OPCABX 3Y*10 if any: UKDA air / oxygen: On RA uts / New Symptoms in last si	,	Date of surg	ery: 99/12/23 ow: _		
A	ASSESSMENT Vital Signs: Temp: Q16_ (°F) Pulse / HR:						
R	Referral of Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections; in nursing care plan: Yes follow-up orders:	No. If Yes, modified		:		
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71/Malc/MH1202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ





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Date: U / D-A	Shift: Morr	ning Evening Night	e de la companya de l	
Ventilator Periphera Ryle's Tu Urinary C	s: (子) 「 PEWS Score: r day: r al line day: Right: 伊诗 Lef be: 日 Yes 日 No Day catheter:日 Yes 日 No Day	v: VIP Score:	days: . —	
Type of s Allergies On room	ROUND surgery: の / エカハ メ ら if any: ゅー / 人れの で air / oxygen: っ / との nts / New Symptoms in last s	م حت لا (V fluids on fl	ery: 28/12/23 ow: -	·
Others: Pain Sco Fall Risk Braden	ore: Minimal Risk: 23-19	/HR: F6 (beats/min) Respira (%) Height: 62 (cms) Weight: : PIPPS / CRIES / FLACC / Wong Bak btocol: Low Medium High At Risk-Mild Risk: 18-15 Moderate Ris SH): Yes No NA Wound D Drain	ker FACES Pain Rating Sca sk: 14-13 High Risk: 12-10 Pressing done: Yes No	le / NRS CPOT
Referral Pending Pending Pending Critical v Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections	No. If Yes, modified care plan date	e:	
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71/Malc/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj



ŀ	PATIE	NT CLINICAL H	IANDOVER RECORI	D FOR NUF	RSES			
Date:)	Date: / / / 2) Shift: Morning Evening Night							
S	Ventilator Periphera Ryle's Tut Urinary C	PEWS Score: — V D day: — Lef be:	vi' y VIP Score: '	0/5.				
В	Allergies i	urgery: $\bigcirc PCPBX$		20 (12	122			
A	ASSESSMENT Vital Signs: Temp: 2 2 Pulse / HR: 8 2 (beats/min) Respiration: 22 (breaths/min) BP: 10 70 (mmHg) Sp02 17 (%) Height: 6 2 (kgs) BMI: 24 M 2 Others: Pain Score: Deain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: Deain Risk: 23-19 At Risk-Mild Risk: 18-15 Moderate Risk: 14-13 High Risk: 12-10 Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): Yes No No No Wound Dressing done: Yes No NA Current diet: Drains:							
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections	Mi L No. If Yes, modified care plan date	e:	; ;			
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71/Malc/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj





Date: 2	1124	Shift: Morn	ing □Evening □Night			
S	NEWS / F Ventilator Periphera Ryle's Tut Urinary C	s: CAD TW EWS Score: 10 day: I line day: Right: Left be: Yes No Day: atheter: Yes No Day:	VIP Score:	6		
В	Allergies i	ROUND Irgery: OFFS Y 3 ge fany: NLDA- air / oxygen: PA- ts / New Symptoms in last sh	. IV fluids on			
Α	Others: Pain Sco Fall Risk Braden S Pressure	re: O Pain Scale used: Score: D Fall Risk Pro	HR:	t: <u>63</u> (kgs) BMI:_ aker FACES Pain Ratir Risk: 14-13	ng Scale / MR	S/CPOT
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8-30	- Due med		per	Si	offn_	
8.45	- Suture : - No cozin - wound site	Lackthy			2oflor_	
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12-30	duty Stoff	ded oce to and	ning	J&	Pn	
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ADULT NURSING CARE PLAN

Mr.KALIYAN S
71/Mulc/MHI202381394
27/12/2023/1PH2023002614
Dr.ANBARASU MOHANRAJ



Initial Date: 2	2/23 Time: 8-00	Modified Date: Time:		
Reason for Modification:		Diagnosis: CAIO LIM TVIO.		_
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep-NPO ☐ Regular Diet	☐ Patient will have adequate nutrition with no nausea and vomiting ☐ Patient will consume daily nutritional	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	M ,	
☐ Others:	requirements in accordance to his activity level and metabolic needs		E Deel	
			Dation + had IDM diet	1
OXYGENATION Room Air Nasal Cannula / High Flow O ₂ Mask BiPAP / CPAP	Patient will have normal O₂ saturation Ratient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains	Encoulage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O₂ saturation and pulse rate		
☐ Ventilator ☐ Tracheostomy ☐ Others:	within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	 If any O₂ abnormalities detected inform immediately to the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis Note for changes in level of consciousness 	E aux	Seloze
		Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging patient with successful coughing	Patient 18 on	
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition	Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Montor intake and output	M	,
Parenteral Nutrition Others:		Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses Monitor for possible sources of fluid loss Monitor BP for orthostatic changes	E Pt takes (D)	Jeofi
			No Chart Manifored	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy	☐ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment	M	
☐ Others:	P_tient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	Consider the need for home assistance (e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	E P4 mobili2001 Weel.	Sil
			Matient Mobilized	(P) +
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention,	Encourage fluid intake Encourage fibre diet intake Encourage early ambulation Report any abnormalities to physician	M	
Urination Others;	control of bowel incontinence, and regular elimination patterns	Observe voiding accessories as foley's / silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	E parter	Jul
		and follow proper protocol Check for malena / constipation / urinary retention	Mormal Elimination Dattorn	
SXIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI	Patient will maintain normal healing status Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment	м	
GRADES OF PRESSURE INJURY ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unistageable			Maristuried (1) E Chin interquete	
☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted		Educate patient and family members about further skin care	E Skir untergiete	Sty
☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			Maintain Normal 8 kin integrity	
	, n		Skin integrity	18/7

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE Bed-Bath Assist-Bath Self-Care CBD Care (if present) Others:	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs Patient will recognize individual weakness or needs	Encourage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene Consider the patient's need for assistive devices Apply moisturizing solution	M E P+ tales Saly Boots	980g
			partient well groomed	1
SAFETY Check ID Hand IV care EJV CENTRAL LINE Side rails	Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails ☐ Provide proper invasive line care ☐ Keep bed locked and low at all time	E ID BOUL	
Others:		☐ Educate care providers to be the patient☐ Follow restrain policy (if needed)	N A	Jees
· · · · · ·		<u>:</u>	ID burd (#)	-\6FA
COMFORT AND SLEEP Pain Control	Patien(will have comfortable sleep Patient will verbalize / or through	Provide clean calm and restful environment Provide privacy at all time	M	
Steep Patterns Others:	behavior about pain relief and adequate sleep	Monitor pain scale / sleep pattern Provide pharmacological and non-pharmacological therapy	EP+ Slooped well	RY
			Provide comportable post	, P
OBSERVATION ☑ Vital S/gns ☐ GCS ☐ Blood Sugar	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality	м	
Others:		Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	E Pt witals are Cheched	Solf
			Noted & Reported	
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness	☐ Pray or encourage the patient to pray☐ Use inspirational words☐ Respond to spiritual needs as they arise	M	
☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	Patient will maintain normal psychological pattern	Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	E	
			As/Chological Support to the pt	arial arial

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Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATION Verbal Non-verbal Sigh language Others:	L	Patient will communic with positive feedbac	cate effectively k	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's or prognosis in the patient's presence	condition	N 1	unialias	Sel
SPECIAL INTE Medication Wound care Isolation Ostomy Care Blood / Blood / transfusion Fluid tapping DVT Managem Others:	products	To manage on time		□ Double check for high alert medication □ Observe and report any medication react □ Provide proper measures of wound care □ Follow hospital polices and protocols of i and explain to the patient / family □ Check for cross matching and typing, to compatibility □ Practice strict asepsis while transfusing be blood products and fluids □ Monitor DVT score and continue treatme as per doctors order	solation ensure slood or	M	munilatión munilatión	
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Patien Mr. KALIYAN S

Name 71/Male/MHI202381394

UHID: 27/12/2023/IPH2023002614

DOB: Dr.Anbarasu mohanraj



ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 28 12 3	Time: 12.00	Modified Date: Time:			
Reason for Modification:		Diagnosis: (AD -+1/D			
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials	
PAIN Comfortable Position Pain Scale	Patient will have less pain	Evaluate location, character, quality and severity of pain Administer pain medication as prescribed and as needed Observe for any changes in vital signs	M		
☐ Pain Score ☐ Others:		Maintain proper positioning of patient Assist or turn patient every two hours Assess incision area for redness, heat, induration,	E Administrational moduration dupor chart	026	
		swelling, separation and drainage Non-Pharmacological therapy	N. Provided Confortable	- Land	
OXYGENATION Room Air Oxygen Hood	Patient will have no shortness or difficulty of breathing	☐ Provide well ventilated environment☐ Check oxygen saturation☐ Perform suctioning if needed	M		
		☐ Ventilator settings as per physician orders ☐ Monitor rate, depth of respiration ☐ Administer oxygen and nebulizer therapy if needed	E ON VENTILATOR SPOS-100X	0.40.	
Uniters.		 Encourage spriometry, deep breathing and coughing exercises Monitor amount, viscosity, colour and odour of sputum if present 	N On Nasal prong	Sulf	
ANXIETY Increased Pulse Rate	Patient will cope properly with his illness and react positively to his	Explain all procedures to patient or family member in simple language they understand	М	,	
☐ Anxious Look	'surroundings: :	☐ Encourage and support patient while increasing anxiety level ☐ Help patient to cope with outcomes of surgery	E		
		☐ Keep patient in comfortable position in bed to enhance sleep	N		
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance	Patient will mobilize freely Patient will perform physical activity independently or within	☐ Apply Anti-Embolic stocking / SCD☐ Evaluate the need for assistive devices☐ Assess the safety of the environment	M		
☐ Physiotherapy ☐ Others:	limits of disease Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of	 ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, 	E 2mmobile	0270	
	adaptive devices to increase mobility	localized swelling, a rise in temperature)	NSafety measured	Cotton	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE Oral Intravenous Enteral Nutrition Parenteral Nutrition Others:	Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	monatored the Chart N. Monitored Ilo Chart	2 To Sta
RISK OF INFECTION Prevent Infection Others:	The patient will be discharged with no hospital acquired infection	Use aseptic technique in all aspect of patient care Restrict visitors and use appropriate PPE Meticulous hand washing before and after patient's care Inspect wound for signs of infection, purulent drainage or discoloration Administer antibiotics as ordered CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	M E you aspotic Procautions polloud N Aseptic technique Followed	\$ 000 to.
RISK OF FALL ☐ Giddiness ☐ Independent State ☐ Dependent State	The patient will have safe, free from fall hospitalization		M E tept bod in Low prolition N Siderails raised	3 7 7 7 5
SKIN &WOUND CARE Observe REEDA Oozing Foul Smell	The patient will have intact skin while staying in the hospital and on discharge	☐ Check all drains from the operation site more frequently ☐ Provide wound care as ordered ☐ Minimize pressure ☐ Provide adequate nutritional support ☐ Report signs of poor healing or trauma to doctor	M E No corregination N No portugat Supplied site	
DIET & NUTRITION NPO Soft Diet Semisolid Diet Solid Diet RT Feeds	Patient will have adequate nutrition with no nausea and vomiting	 ☐ Encourage patient to consume prescribed diet ☐ Record amount of food consumed ☐ Provide high calories, high protein diet as prescribed ☐ Monitor patient's weight ☐ Administer supplemental vitamins and minerals as prescribed ☐ Administer parentral or TPN per protocol if dietary needs are not met through oral intake ☐ Report abdominal distention, large gastric residual volume or diarrhea to doctor 	M E NPD N Potient Consumod liquid diet	9 3 3 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5

Patient Specifi Problems / Ne		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initjals
CARE OF CAT DRAINS, ETC.		Patient will have patent, properly maintained catheters, drains etc	☐ Check the catheters, drains etc frequently ☐ Observe I/O Chart ☐ Watch for any symptoms related to kinked or blocked tubes ☐ Maintain adequate cleaning and dressing	M Montaine	J 2 to J J CB D 1
DISTURBED B	BODY IMAGE	The patient will demonstrate initial acceptance and to newly body image	 Note non verbal body language, negative attitude and self talk Note emotional reaction (grieving, depression, and Acknowledge and accept expression of feeling of grief and hostility 	·	
OBSERVATION ✓ Vital Signs ✓ GCS ✓ Blood Sugar ✓ Others:	N	Patient will have normal range of vital parameters	Monitor vital signs regularly Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient	M montoned	vogularly = 5-76.
HEALTH EDUC Patient Family / Guard Diet Disease proces Infection contro Medication Educate about and immunosu Personal Safety Treatment Region	ian ss ol / PPE TAC level ippressant	Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	☐ Provide proper education regarding follow-up diet ☐ Insist on importance of hand hygiene ☐ Explore action, reactions and adherence about m ☐ Provide clear, thorough, and understandable explaregarding safety precautions. ☐ Explain to perform activities / skin care that recomby concerned doctor ☐ Use the teach-back technique to determine the parameters and ingregarding importance of treatment.	edication anations mended tient's	about condition of the stay
Others:	IEEDS			M E	ect som
	Signature	Name	Emp.	N Date	Time
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71/Male/MHi202381394 27/12/2023/iPH2023002614

Dr.ANBARASU MOHANRAJ





ADULT POST-OPERATIVE NURSING CARE PLAN

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Initial Date: 09 12	23 Time: 700	Modified Date: Time:		
Reason for Modification:		Diagnosis: CAD ~ JVD .		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
PAIN ☐ Comfortable Position ☐ Pain Scale	Patient will have less pain	Evaluate location, character, quality and severity of pain Administer pain medication as prescribed and as needed Observe for any changes in vital signs	modulies for all des usbadies	OBOTA
☐ Pain Score ☐ Others:		☐ Maintain proper positioning of patient ☐ Assist or turn patient every two hours ☐ Assess incision area for redness, heat, induration.	E Administryed by androsis	(Pay) HA
		swelling, separation and drainage Non-Pharmacological therapy	N Proceeded Configuration	
OXYGENATION Room Air Oxygen Hood	Patient will have no shortness or difficulty of breathing	Provide well ventilated environment Check oxygen saturation Perform suctioning if needed	M SPRY-9AY, ON TROOTS	ORW)
Nasal Cannula Nebulizer Ventilator Others:		□ Ventilator settings as per physician orders □ Monitor rate, depth of respiration □ Administer oxygen and nebulizer therapy if needed □ Encourage spriometry, deep breathing and	E Spoy-91% ON TOOM	alais A
		coughing exercises Monitor amount, viscosity, colour and odour of sputum if present	n on Room Air,	eh 700%
ANXIETY Increased Pulse Rate	Patient will cope properly with his illness and react positively to his	Explain all procedures to patient or family member in simple language they understand	М	•
☐ Anxious Look	. surroundings	☐ Encourage and support patient while increasing anxiety level ☐ Help patient to cope with outcomes of surgery	E the is ropporative	Now 3-24
		Keep patient in comfortable position in bed to enhance sleep	N	10
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease	☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance	M ON bal root	South
Others:	Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of	(e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness,	E ON chair part	Paris +1
	adaptive devices to increase mobility	localized swelling, a rise in temperature)	n mobilized	S EN

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE Oral- Intravenous Enteral Nutrition Parenteral Nutrition Others:	Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M Moderal Sto E Stive potant and halther N De Loatthy	ANO 14 ANO 84 STO
RISK OF INFECTION ☐ Prevent Infection ☐ Others:	☐ The patient will be discharged with no hospital acquired infection	Use aseptic technique in all aspect of patient care Restrict visitors and use appropriate PPE Meticulous hand washing before and after patient's care Inspect wound for signs of infection, purulent drainage or discoloration Administer antibiotics as ordered CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	M doppie tachiques alberd. E doppie tachiques N procautions follows	Obuls Obuls Obuls 5276
RISK OF FALL Giddiness Independent State Dependent State	☐ The patient will have safe, free from fall hospitalization	Keep bed on low position Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed Remove clutter, keep items patient needs within reach Avoid movement out of bed after surgery for:46 hours Review patients' medication like narcotics and hypotensive agents Offer urinal or bedpan to the patient if needed	M fall risk pracultion E fall risk pracultion N Fall risk placed. N broadstone follows.	Vants Vants Vants Statio
SKIN &WOUND CARE Observe REEDA Oozing Foul Smell	☐ The patient will have intact skin while staying in the hospital and on discharge	Check all drains from the operation site more frequently Provide wound care as ordered Minimize pressure Provide adequate nutritional support Report signs of poor healing or trauma to doctor	M drain mostly E could hally N , would treatthy	Charles Conta Vanisha St
DIET & NUTRITION NPO Soft Diet Semisolid Diet Solid Diet RT Feeds	Patient will have adequate nutrition with no nausea and vomiting	 ☐ Encourage patient to consume prescribed diet ☐ Record amount of food consumed ☐ Provide high calories, high protein diet as prescribed ☐ Monitor patient's weight ☐ Administer supplemental vitamins and minerals as prescribed ☐ Administer parentral or TPN per protocol if dietary needs are not met through oral intake ☐ Report abdominal distention, large gastric residual volume or diarrhea to doctor 	M ON liquid dist N Soft allot	Vanish Str

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Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign &
CARE OF CAT DRAINS, ETC.		Patient will have patent, maintained catheters, di		Check the catheters, drains etc frequently Observe I/O Chart Watch for any symptoms related to kinker blocked tubes Maintain adequate cleaning and dressing	d or	M ON CBD LOTTED OF E CN CBD LITTE N ON CBD LITTE N ON CBD LITTE		0 4
DISTURBED B	ODY IMAGE	☐ The patient will demons initial acceptance and to body image		□ Note non verbal body language, negative and self talk □ Note emotional reaction (grieving, depresed to the procession of force of grief and hostility	ssion, anger)	M E		
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	N	Patient will have normal of vital parameters	range	Monitor vital signs regularly Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient		M Hoomedynamically E flaction your of N cliftals y	Stable by horiston,	Juis 4
HEALTH EDUC Patient Family / Guardi Diet Disease proces Infection contro Medication Educate about and immunosu Personal Safety Treatment Regi Others:	ian ss ol / PPE TAC level ppressant	Patient / Family / Guardi Domestic Partner / Care others will gain adequat knowledge regarding tre modalities and life style modifications	e-giver / se eatment	Provide proper education regarding follow Insist on importance of hand hygiene Explore action, reactions and adherence Provide clear, thorough, and understandar egarding safety precautions. Explain to perform activities / skin care the by concerned doctor Use the teach-back technique to determine understanding regarding importance of treest the second sec	about medication able explanations at recommended ne the patient's	EXPLORING CHOOL N CONSTITUTION CONTROL EXPLORING N EXPLORING N THE PT	Itie Jedg (ju o en about Cordetê	Vanis EOFA Proch
ANY OTHER N	EEDS					M E N		
	Signature	 	Name		Emp. ID	Date		Time
Endorsed by	1			Amour'	no 01	30(12/15	9. W





71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ





ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 30/12/2	3 Time: 7.10	Modified Date: Time:				
Reason for Modification:	. 	Diagnosis: CAD -TVI)				
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials		
PAIN ☐ Comfortable Position ☐ Pain Scale ☐ Pain Score ☐ Others:	Patient will have less pain	Evaluate location, character, quality and severity of pain Administer pain medication as prescribed and as needed Observe for any changes in vital signs Maintain proper positioning of patient Assist or turn patient every two hours Assess incision area for redness, heat, induration, swelling, separation and drainage Non-Pharmacological therapy	Moderniesteral dus Modicilier as pay Chart E provident contortit position N & Had Dull pain	Chow of 4		
OXYGENATION Room Air Oxygen Hood Nasal Cannula Nebulizer Ventilator Others:	Patient will have no shortness or difficulty of breathing	Provide well ventilated environment Check oxygen saturation Perform suctioning if needed Ventilator settings as per physician orders Monitor rate, depth of respiration Administer oxygen and nebulizer therapy if needed Encourage spriometry, deep breathing and coughing exercises Monitor amount, viscosity, colour and odour of sputum if present	M SPOX-914. ON YOUND BY ESport 90 A. N Pt on room air 92%	Hay		
ANXIETY Increased Pulse Rate Anxious Look	Patient will cope properly with his illness and react positively to his surroundings	 □ Explain all procedures to patient or family member ip simple language they understand □ Encourage and support patient while increasing anxiety level □ Help patient to cope with outcomes of surgery □ Keep patient in comfortable position in bed to enhance sleep 	M (copyratal and)	Voui?		
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	□ Apply Anti-Embolic stocking / SCD □ Evaluate the need for assistive devices □ Assess the safety of the environment □ Consider the need for home assistance (e.g., physical therapy, visiting nurse) □ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M ON chair fast E Pt mobilipmed Ptmohised will Principles	Herry Herry		

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE Oral Intravenous Enteral Nutrition Parenteral Nutrition	Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such	M Ir live perbud & hoolthy	Sais Coot4
Others:		as diaphoresis, wound drainage, and gastric losses Monitor for possible sources of fluid loss Monitor BP for orthostatic changes	N Enloulaged	SIN
			adequate Intare	Histor
RISK OF INFECTION Prevent Infection Others:	☐ The patient will be discharged with no hospital acquired infection	Use aseptic technique in all aspect of patient care Restrict visitors and use appropriate PPE Meticulous hand washing before and after patient's care	M doubic toohigton	Office \$4
		☐ Inspect wound for signs of infection, purulent drainage or discoloration☐ Administer antibiotics as ordered	E	
		CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	N	
RISK OF FALL ☐ Giddiness ☐ Independent State	☐ The patient will have safe, free from fall hospitalization	Keep bed on low position Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed Remove clutter, keep items patient needs within reach	M fall risk precultion	(1600) (1500-4
☐ Dependent State		Avoid movement out of bed after surgery for 46 hours Review patients' medication like narcotics and hypotensive agents	E	
		Offer urinal or bedpan to the patient if needed	N -	
SKIN &WOUND CARE Observe REEDA Oozing	The patient will have intact skin while staying in the hospital and on discharge	Check all drains from the operation site more frequently Provide wound care as ordered	M comend hostily	Chais of 4
Foul Smell	Si distribuige	Minimize pressure Provide adequate nutritional support Report signs of poor healing or trauma to doctor	E	
		Theport signs of poor fleating of trauffia to doctor	N _	
DIET & NUTRITION NPO Soft Diet Semisolid Diet	Patient will have adequate nutrition with no nausea and vomiting	□ Encourage patient to consume prescribed diet □ Record amount of food consumed □ Provide high calories, high protein diet as prescribed □ Monitor patient's weight	M ON Objet would did	Odulo FOOTH
Solid Diet RT Feeds		Administer supplemental vitamins and minerals as prescribed Administer parentral or TPN per protocol if dietary	E pt hood Norman	AN MAN
		needs are not met through oral intake Report abdominal distention, large gastric residual volume or diarrhea to doctor	N Pthad Dm diet	Hout

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Patient Specific Problems / Needs		Measurable Goals		Nursing Interventions		Evaluation		Sign & . . Initials
CARE OF CATHETERS, DRAINS, ETC.		Patient will have patent, properly maintained catheters, drains etc		Check the catheters, drains etc frequently Observe I/O Chart Watch for any symptoms related to kinked or blocked tubes Maintain adequate cleaning and dressing		M ON CBP COLPUTE E = 10 cl	alquote men force	Hong stor
DISTURBED BODY IMAGE		☐ The patient will demonstrate initial acceptance and to newly body image		 Note non verbal body language, negative attitude and self talk Note emotional reaction (grieving, depression, anger) Acknowledge and accept expression of feeling of grief and hostility 		M E		
OBSERVATION Vital Signs GCS Blood Sugar Others:		☐ Patient will have normal range of vital parameters		Monitor vital signs regularly Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient		M Harmon newally stable. E I Li wy Stable N Pt vital signs as a constable		Charles of the state of the sta
HEALTH EDUCATION Patient Family / Guardian Diet Disease process Infection control / PPE Medication Educate about TAC level and immunosuppressant Personal Safety Treatment Regimen Others:		Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications		Provide proper education regarding follow-up diet Insist on importance of hand hygiene Explore action, reactions and adherence about medication Provide clear, thorough, and understandable explanations regarding safety precautions. Explain to perform activities / skin care that recommended by concerned doctor Use the teach-back technique to determine the patient's understanding regarding importance of treatment		M gained knowadge on importance of how hy give E Hearth accounting N Health education was given		POOR TOWN
ANY OTHER NEEDS						M E N		
	Signature	Name			Emp. ID		Date	Time
Endorsed by	Q ,		C	Imiu.	000		30/12/25	9-RD

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71/Male/MHI202381394 27/12/2023/JPH2023002614

Dr.ANBARASU MOHANRAJ





ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: SI 12 28	Time: 8:00	Modified Date: Time:				
Reason for Modification:		Diagnosis: CAD -TVD				
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initlals		
PAIN ☐ Comfortable Position ☐ Pain Scale /	Patient will have less pain	☐ Evaluate location, character, quality and severity of pain☐, Administer pain medication as prescribed and as needed☐ Observe for any changes in vital signs	M pt Dina buel	OD)		
Pain Score Others:		☐ Maintain proper positioning of patient ☐ Assist or turn patient every two hours	E Pt rates National	Deg		
		Assess incision area for redness, heat, induration, swelling, separation and drainage Non-Pharmacological therapy	N Pt hard Dull pain	Hay		
OXYGENATION ☐ Room Air ☐ Oxygen Hood	Patient will have no shortness or difficulty of breathing	☐ Provide well ventilated environment☐ Check oxygen saturation☐ Perform suctioning if needed	M pt your our	8		
Uxygen Hood Nasal Cannula Nebulizer Ventilator Others:		□ Ventilator settings as per physician orders □ Monitor rate, depth of respiration □ Administer oxygen and nebulizer therapy if needed □ Encourage spriometry, deep breathing and	E wow and	John		
		coughing exercises Monitor amount, viscosity, colour and odour of sputum if present	NPt stable on	Hery		
ANXIETY Increased Pulse Rate	Patient will cope properly with his illness and react positively to his	☐ Explain all procedures to patient or family member in simple language they understand	M pt Normal Vitell	8		
☐ Anxious Look	surroundings	☐ Encourage and adpport patient while increasing anxiety level ☐ Help patient to cope with outcomes of surgery	E PT Witau all Chocke	Joli		
		Keep patient in comfortable position in bed to enhance sleep	N	· · · · · · · · · · · · · · · · · · ·		
MOBILITY Mobile / Immobile Walk with assistance	☐ Patient will mobilize freely☐ Patient will perform physical activity independently or within	□ Apply Anti-Embolic stocking / SCD □ Evaluate the need for assistive devices □ Assess the safety of the environment	M pt mobiliza Frealy	Dur		
☐ Physiotherapy ☐ Others:	limits of disease Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of	Consider the need for home assistance (e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness,	EP+ mobilized	Seefor		
	adaptive devices to increase mobility	localized swelling, a rise in temperature)	N pt mobilized well	Hay		

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE Oral Intravenous Enteral Nutrition Parenteral Nutrition Others:	Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	M pt electrolytes Fluid E pt electrolytes fluid N Eneoneaged N adequate intote	Jack Jack Tolor
RISK OF INFECTION Prevent Infection Others:	The patient will be discharged with no hospital acquired infection	☐ Use aseptic technique in all aspect of patient care ☐ Restrict visitors and use appropriate PPE ☐ Meticulous hand-washing before and after patient's care ☐ Inspect wound for signs of infection, purulent drainage or discoloration ☐ Administer antibiotics as ordered ☐ CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	M pt discherere Enfortun E teloured frontic	& Jan
RISK OF FALL Giddiness Independent State Dependent State	☐ The patient will have safe, free from fall hospitalization.		Mp+ hospitaliseties E there ies no any other complainte	Det Sey on
SKIN &WOUND CARE Observe REEDA Oozing Fout Smell	The patient will have intact skin while staying in the hospital and on discharge	□ Check all drains from the operation site more frequently □ Provide wound care as ordered □ Minimize pressure □ Provide adequate nutritional support □ Report signs of poor healing or trauma to doctor	M pt Slan nospidul E there is no any Ooring N	Before
DIET & NUTRITION NPO Soft Diet Semisolid Diet Solid Diet RT Feeds	Patient will have adequate nutrition with no nausea and vomiting	 □ Encourage patient to consume prescribed diet □ Record amount of food consumed □ Provide high calories, high protein diet as prescribed □ Monitor patient's weight □ Administer supplemental vitamins and minerals as prescribed □ Administer parentral or TPN per protocol if dietary needs are not met through oral intake □ Report abdominal distention, large gastric residual votume or diarrhea to doctor 	M E N Patient had hoomal diet	tay ora

Patient Specific Problems / Needs		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
CARE OF CATHETERS DRAINS, ETC.			nt, properly drains etc	☐ Watch for any symptoms related to kinked or		M pr main	tainel	ey-
/				blocked tubes Maintain adequate cleaning and dressing)	E · _		_
						N Itoch	acto	Hay Gebs
DISTURBED BODY IM	AGE	The patient will demoi		Note non verbal body language, negative and self-talk	e attitude	Mp+ in	alexeptane	8
		body image	·	 Note emotional reaction (grieving, depression of formal price of grief and hostility 	ssion, anger) eeling		samuri cata	Ber
				or grot and trouting		N ~	-	1
		Patient will have norm	al range	☐ Monitor vital signs regularly☐ Assess physically for any abnormality		M p+ vitec	l seny	20
☐ GCS ☐ Blood Sugar ☐ Others:				☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient		E Pt witd	e are	Jeegle
Others.						N Pt virtal	Signs all	Hay
HEALTH EDUCATION Patient Family / Guardian Diet		Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life etyle modifications		 □ Provide proper education regarding follow-up diet □ Insist on importance of hand hygiene □ Explore action, reactions and adherence about medication □ Provide clear, thorough, and understandable explanations regarding safety precautions. □ Explain to perform activities / skin care that recommended by concerned doctor □ Use the teach-back technique to determine the patient's understanding regarding importance of treatment 		MP7 CC	uarolicy	all a
☐ Disease process☐ Infection control / PPE☐ Medication☐ Educate about TAC leven and immunosuppressa	rei					1 ((~-	clour ie o to eep	Hefer
☐ Personal Safety ☐ Treatment Regimen ☐ Others:						N Health	h education Liven	Hay
ANY OTHER NEEDS						M		
						E		
						N	_	
Signa	ature		Name		Emp. ID		Date	Time
Endorsed by	مرحور		g. Nalin		0084		21/12/23	15100





ADULT NURSING CARE PLAN

Mr.KALIYAN S

71/Malc/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ





Initial Date: 1/1/24	Time: 800	Modified Date: Time:		
Reason for Modification:		Diagnosis: CAD - TVD		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	MPt had DM didt E Pt had Dang N Pt had D dw	Son!
OXYGENATION Room Air Nasal Cannula / High Flow O₂ BiPAP / CPAP Ventilator Tracheostomy Others:	Patient will have normal O₂ saturation Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	□ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises □ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order □ Utilise pulse oximetry to check O₂ saturation and pulse rate □ If any O₂ abnormalities detected inform immediately to the concerned physician □ Place patient with proper body alignment for maximum breathing pattern □ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis □ Note for changes in level of consciousness □ Send sputum for culture and sensitivity based on	MPE US ON YOUM OLD E Sport ON ON ON ON ON ON ON ON ON O	Jahr Story
	☐ Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing	N SP02-984,	007	
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition Parenteral Nutrition Others:	Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses ☐ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes	m Ilo Chaoct monitored Eslo Charlowed N Plo Chart Montored Montored	Mah.

Patient Specific Sign & **Nursing Interventions** Measurable Goals Evaluation Problems / Needs Initials MOBILITY ☐ Patient will mobilize freely Encourage regular ambulation ROM exercise Mobile / Immobile ☐ Apply Anti-Embolic stocking / SCD Patient will perform physical ☐ Walk with assistance activity independently or within Evaluate the need for assistive devices ☐ Physiotherapy limits of disease Assess the safety of the environment ☐ Others: ☐ P⊥tient will use safety measures ☐ Consider the need for home assistance to minimize potential for injury (e.g., physical therapy, visiting nurse) ☐ Patient will demonstrate the use of ☐ Note for progressing thrombophlebitis adaptive devices to increase mobility (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature) Ν M NOT mal Elimination

Pattoon

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putten N Patient will have normal elimination N Encourage fluid intake **ELIMINATION** ☐ Encourage fibre diet intake ☐ Encourage early ambulation Catheter, bedpan, urinal ☐ Nasogastric tube ☐ Patient will control of urinary ☐ Bowel movement in-continence or urinary retention. Report any abnormalities to physician ☐ Urination control of bowel incontinence, ☐ Observe voiding accessories as foley's / ☐ Others: and regular elimination patterns silicone catheter ☐ Check placement before feeding☐ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol Check for malena / constipation / urinary retention Ν Patient will maintain normal Minimize / Eliminate friction and shear **SKIN INTEGRITY** Maintain pormal skin integrity healing status Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces Pressure points site ☐ Patient will discharge with intact assessment skin integrity and devices ☐ HAPI ☐ OPI ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin
Maintain adequate nutrition and hydration **GRADES OF PRESSURE** INJURY ☐ GRADE 1 ☐ GRADE 2 Proper application of medications and dressing ☐ GRADE 3 ☐ GRADE 4 Follow doctors and TVN order properly ☐ Monitor the healing status ☐ Unstageable Ε ☐ Deep Tissue Injury Educate patient and family members about further ☐ Healing Status skin care ☐ PUSH Decreased PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given Ν Others:

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Patlent Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☑ Bed-Bath ☑ Assist-Bath ☑ Self-Care	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs Patient will recognize individual weakness or needs	Encourage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene Consider the patient's need for assistive devices Apply moisturizing solution	MPt 4000 régione E -	Hogy C
SAFETY Check ID Hand IV care EJV CENTRAL LINE Side rails Others:	Patient will have no life-threatening situations	Check the identity with ID band before any interaction with the patient Raise side rails Provide proper invasive line care Keep bed locked and low at all time Educate care providers to be the patient Follow restrain policy (if needed)	MID Band Prosent E = D karef N Rd bound Chreek	Parl Det
COMFORT AND SLEEP Pain Control Sleep Patterns Others:	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and adequate sleep	☐ Provide clean calm and restful environment ☐ Provide privacy at all time ☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	M _ E N	
OBSERVATION Vital Signs GCS Blood Sugar Others:	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	M Vital Signs Echeckery Exocordod Exocordod N Vitals ovel Stable	Palk!
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Beliefs / Values / Customs Anxiety and Copying Pattern Identify Stressors Others:	□ Patient will achieve spiritual needs □ Patient will be able to control his feeling toward his illness □ Patient will maintain normal psychological pattern	Pray or encourage the patient to pray Use inspirational words Respond to spiritual needs as they arise Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	ME	

Patient Specific Sign & **Nursing Interventions** Measurable Goals Evaluation Initials Problems / Needs Introduce the care giver
Encourage the use of call bell
Obtain interpreter if needed Patient will communicate effectively CQMMUNICATION m Pt 4000 with positive feedback **√**erbal ☐ Non-verbal ☐ Sigh language No negative speaking about the patient's condition Others: or prognosis in the patient's presence SPECIAL INTERVENTIONS To manage on time Double check for high alert medication Observe and report any medication reaction
 Provide proper measures of wound care Medication Mound care Follow hospital polices and protocols of isolation ☐ Isolation and explain to the patient / family Ostomy Care ☐ Blood / Blood products ☐ Check for cross matching and typing, to ensure transfusion compatibility Practice strict asepsis while transfusing blood or ☐ Fluid tapping blood products and fluids DVT Management Others: ☐ Monitor DVT score and continue treatment as per doctors order Time Name Emp. 1D Date Signature C. Nulini CO!81 0024 Endorsed by





ADULT NURSING CARE PLAN

P. Mr.KALIYAN S

N 71/Male/MHI202381394

U. 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ





Initial Date: 🏈 🔰 🛭	4 Time: 7,130	Modified Date: Time:			
Reason for Modification:	,	Diagnosis: CAD-TUD	Diagnosis: CAD-TUD		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials	
NUTRITION ☐ Keep NPO ☐ Regular Diet ☐ Others:	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional requirements in accordance to his	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	M DM diet	Polin	
others.	activity level and metabolic needs		N .		
OXYGENATION Boom Air Nasal Cannula / High Flow O₂ Mask BiPAP / CPAP Ventilator	Patient will have normal O₂ saturation Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains within established limits	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O₂ saturation and pulse rate ☐ If any O₂ abnormalities detected inform immediately to	M Patit is on	lston	
☐ Tracheostomy ☐ Others:	within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis Note for changes in level of consciousness	E		
		Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging patient with successful coughing	N		
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition Parenteral Nutrition Others:	Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output ☐ Measure or estimate fluid losses from all sources such as diaphoresis, wound drainage, and gastric losses	M Cakes adoquate ord	dh	
3.0.0		Monitor for possible sources of fluid loss Monitor BP for orthostatic changes	N		

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Putient will use safety measures	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance	M Pt mobilized well	Pethn
Culets.	to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	(e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	E	
		· 	N	
ELIMINATION Catheter, bedpan, urinal Másogastric tube Bowel movement	Patient will have normal elimination / pattern Patient will control of urinary in-continence or urinary retention,	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician	M Self voiding	Poln
Others:	control of bowel incontinence, and regular elimination patterns	Observe voiding accessories as foley's / silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	E	
. ,		and follow proper protocol Check for malena / constipation / urinary retention	N	
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI DPI GRADES OF PRESSURE	☐ Pattent will maintain normal healing status ☐ Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin	M No oozeng in Sugich site	Idn
INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased		Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	E	
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N	

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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sigń & Iņitials
HYGIENE Bed-Bath Assist-Bath	Patient will stay clean and well-groomed Patient will demonstrate lifestyle	Encourage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene	M pt well gramed	Poffer.
☐ Self-Care ☐ CBD Care (if present) ☐ Others:	changes to meet self-care needs Patient will recognize individual weakness or needs	Consider the patient's need for assistive devices Apply moisturizing solution	E	
			N	
SAFETY Check ID Hand	Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails	MID bad @	Aln
☐ IV care ☐ EJV CENTRAL LINE ☐ Side rails ☐ Others:		Provide proper invasive line care Keep bed locked and low at all time Educate care providers to be the patient	E	, -
		Follow restrain policy (if needed)	N	
COMFORT AND SLEEP Pain Control	Patient will have comfortable sleep Patient will verbalize / or through	Provide clean calm and restful environment Provide privacy at all time	M	_
Sleep Patterns Others:	behavior about pain relief and adequate sleep	Monitor pain scale / sleep pattern Provide pharmacological and non-pharmacological therapy	E	
· ·			N	
OBSERVATION	Patient will have normal range of vital parameters	☐ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality	M Vital Sighs choked	PHN
☐ Blood Sugar ☐ Others:		☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	E	77672
			N	
PSYCHOLOGICAL /	☐ Patient will achieve spiritual needs	☐ Pray or encourage the patient to pray		
SPIRITUAL SUPPORT Spiritual Needs Beliefs / Values / Customs	Patient will be able to control his feeling toward his illness Batlent will maintain normal	Use inspirational words Respond to spiritual needs as they arise Evaluate spiritual needs	M Provided Psychology	812
☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	psychological pattern	Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	E	
-	,		N	

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Patient Specific Sign & **Nursing Interventions Measurable Goals Evaluation** Problems / Needs Initials Patient will communicate effectively Introduce the care giver COMMUNICATION М ☐ Encourage the use of call bell☐ Obtain interpreter if needed ☐√Verbal with positive feedback Nón-verbal No negative speaking about the patient's condition ☐ Sigh language Ε or prognosis in the patient's presence Others: N □ Double check for high alert medication
 □ Observe and report any medication reaction
 □ Provide proper measures of wound care
 □ Follow hospital polices and protocols of isolation SPECIAL INTERVENTIONS ☐ 70 manage on time m modications given as per chart Medication
Wound care ☐ Isolation and explain to the patient / family ☐ Ostomy Care ☐ Blood / Blood products ☐ Check for cross matching and typing, to ensure E transfusion compatibility Practice strict asepsis while transfusing blood or ☐ Fluid tapping DVT Management blood products and fluids ☐ Monitor DVT score and continue treatment Others: as per doctors order Ν Name Emp. ID Date Time Signature C. Nalin 211184 160 0024 Endorsed by





Patient DAL-12
Mr.KALIYAN S
71/Malc/MHI202381394
27/12/2023/12H2023002614
Dr.ANBARASU MOHANRAJ



BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISK Time:	8	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1.Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4
MOISTURE degree to which skin is exposed to moisture	1.Constantly Molst 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	9	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	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	7	}
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	4	4
FRICTION & SHEAR	1.Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. N or chair		3, 23	3 23
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	TO /	





Patient I 71/Malc/MHI202381394 27/12/2023/IPH2023002614 Name: Dr.Anbarasu mohanraj UHID: DOB: DOA: Consultant:



BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISK Time:	3-00		
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1 Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited 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		1	3
MOISTURE degree to which skin is exposed to moisture	X: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			2
ACTIVITY degree of physical activity	2. 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	l
MOBILITY ability to change and control body position	1. Completely Immobile Poes not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance		1	2
NUTRITION usual food intake pattern	Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	Usually eats a total of 4 or		1	2
FRICTION	1/Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		1	1	2
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or	chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally		TOTAL SCORE	b	6	12
	agitation leads to almost constant friction	slides down		of Staff Nurse:	23 to		Xa
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	of Sr. Staff Nurse:		1 4	13





71/Malc/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ





Date: 1/2 2112

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK Time:	13.00	91-5P	Ro J
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			710- 7400
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Molst Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	2	2_	2
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	۱۹	Ω	_2
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	2	0-	2
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Harely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	2	2	2
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently		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		2	2_	2
& SHEAR	slides down in bed or chair, requeiting frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction		orchair	TOTAL SCORE Initial & Emp. No of Staff Nurse:	13 100H	13 8 02-6	13
Score	Interpretation: Minimal Risk: 23 - 19; At Risk	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	A	R.	1





Patient Details (Affix Label here)
Name: mr 'lac' | yan,
UHID:
DOB: Tylm 202381394
DOA: 27/12/230025000614

MHI/NUR/2022/045 Medway Heart Institute

(A Unit of United All	llance Healthcare Pvt Ltd)		Consultant: Dr. Abbaragu	. Date	30 R	(7)	, dire
	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISK Time:		N	
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	cannot always communicate discomfort or the need to be turned OR had some	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	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. Oceasionally Molst Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Molst Skin is usually dry, linen only requires changing at routine intervals		3	
ACTIVITY degree of physical activity	1. Bedfast 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	
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4 No Limitation Makes major and frequent changes in position without assistance	4	4	
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement	LA. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	7	M	
FRICTION	Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	strength to lift up completely during move. Maintains good position in bed			3	
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down		Initial & Emp. No.		20 164	
Score	agitation leads to almost constant friction of 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 Initial & Emp. No. of Sr. Staff Nurse:						





71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr,Anbarasu mohanraj





Every heart beat counts

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







MHI/NUR/2022/045

Medway

Heart

Institute

Every heart beat counts

Date:

	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISK Time:	m	E_	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	3	>	37
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	Q	•	3
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Stight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance		3	3
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	7	3	3
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides to some extent against sheets, or chair 2. Potential Problem Moves feebly or requires minimum assistance buring a move skin probably strength to lift up completely during move. Main or chair			9	ク	3	
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction			TOTAL SCORE Initial & Emp. No. of Staff Nurse:	19	m	19
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	Pos	195	عم

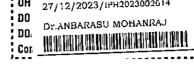




Par Mr.KALIYAN S

Na 71/Male/MHI202381394

UH 27/12/2023/IPH2023002614





(A Unit of United Al	llance Healthcare Pvt Ltd)		Cor hada minima ma katematema ma ma ma ma ma ma ma ma ma ma ma ma m				T .
	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISK Time:	194	4	2H N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort		1	
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Molst Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Barely Moist &kin is usually dry, linen only requires changing at routine intervals			
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours			
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance			
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation			
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. N or chair	aintains good position in bed TOTAL SCORE	3 23 outr		
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	' Mild Risk: 18 - 15; Moderate Risk: 14 - 13; F	ligh Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	المعالم		







Patien Mr. KALIYAN S
Name 71/Male/MHJ202381394
27/12/2023/IPH2023002614
DDB: Dr. ANBARASU MOHANRAJ

Consument

Heart Institute

MHI/NUR/2022/052

very heart beat counts

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. Nó.
18/2/s	. O to	C-por		-		<u>भ</u>	Vasos
15-00	9 50	C-poT		.		2276	Vas
17.00	100	Dull Pain	50C T10-13	surgical site	un_Phormacocogtal Phtomonton done	270	Kows
19.00	Yw	Achy polin	200	stamum	don-pharmacological Dentoniantion done	0270	Yous
21:00	1/10	Dul pain	Llo dece	Stornem	Non-phaemacological interention given	Bull	A Sous
<u> ত</u> ্যান্ত		Datient is blooper	LÇ.	,	-	5203	200)
<u>100!00</u>		patient is &	leopir	79.		Suff.	of son
02100		patient 18 sl	eofi'r	٧ ٠	<u> </u>	87	You
04;00		patient is &	doop	7,		84	N Dal

dull, achy	ain Character sharp, stabbing, shooting, , referred / radiant pain)	Duration	Location / Site	Ir	nterventions			Staff Ini & Emp.	tiai		r Staff al & . No.
ab 100 /10 Du	U Pain	<u> L88cu</u>	Steenum	Non-pharmac	les ifetos	inter jiven	entos	62	ഹ	A	, _T g^?
8.00 2/10 de	hy pain	10-15 Ose	Of Ear weens	Phormacological Lie	anage mont	Dow	,	glands out	4	d	(0°3)
10-00 1/10 dal	U paén	2 5	- Atornum	New phormordog	icd manage	Mout	Dow.	Charles Cont	A	di	0007
109.00 1/10	lull poin	<10 Noe.	Melrastines	n Cougoslable po	U Unhalen gr	iven.		How?	a' ·		/go ⁷ .
		1 1	PA	AIN SCALES	.						
PIPPS (28 weeks to <u><</u> 38 weeks)	6 or less = Minimal to no p 7 - 12 = Mild pain - Provide >12 = Moderate to severe	e comfort me		pn .		ı	4	· · · ·	,	,	1 ''
CRIES (38 weeks - 2 months)				of gestation. A maximal score resic administration is indicated			ES score Is >	4,		.•	; ,
FLACC Scale (2 months - 7 years)	0: Relaxed & comfortable	, 1-3: Mild di	scomfort, 4-6: Mode	rate discomfort, 7-10: Severe d	llscomfort / pain	/ both	,		_		
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	O 2 No Hurts Little Bit	4 Hurts Little Moro	6 Hurts Even More	8 10 Hurts Whole Lot Worst	Numerica 0 1 2 None Mi	2 3	Gcale (age	more than	12 y	9	
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	COMPLIANCE WITH VEN	Absence of m TILATION (libated patier elaxed, 1 - Te	ovements or normal p ntubated patients): 0 nts): 0 - Talking on no nse, Rigid, 2 - Very Te	position, 1 - Protection, 2 - Restle - Tolerating Ventilator or Movem- rmal tone or no sound, 1 - Sighin nse, Rigid	ent , 1 - Coughing	but toleration		g ventilator (d	or)		
Non-pharmacological Interventions	Cutaneous Stimulation ar Thermal Theraples (no lor	nd massage: nger than 15	E - Positioning; F - R to 20 minutes): G - Co	- Music; D - Physical and mental ubbing / Massage the skin old application; H - Hot application or Fernial therapy Psycho-soc	on; 1 - Shortwave d		Individual Cou	nseling; L - Fa	amily	counse	ling
Pharmacological Intervention	is as per doctor's prescript	lon							_		





PAIN RE-ASSESSMENT & MONITORING CHART



Mr.KALIYAN S

71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ



MHI/NUR/2022/052



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.
14-00	0	No paeis		-		Deles	(De)
18-00						Den	() () () () () () () () () ()
92. 0 0		No Pain		-	•	Pho	(Ib)
0 0 5 5 5 5		V		prom		0170	(D)
6.00	olin	No pain	ł	•		A	OZ L

Date & Time	Pain Score	(duli, achy	ain Character sharp, stabbing, shooting, referred / radiant pain)	Duration	Location / Site	Inter	ventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
			·						
									,
					P#	IN SCALES	_		<u> </u>
(28 week	PIPPS (8 to <u><</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	e comfort me		n	•		,
(38 we	CRIES eks - 2 m	onths)				of gestation. A maximal score of 1 gesic administration is indicated for	0 is possible. If the CRIES score is > 4, r a score of 6 or higher.	' '	,
	ACC Sca nths - 7 y		0: Relaxed & comfortable	e, 1-3: Mild d	Iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe disco	omfort / pain / both		
Pain	-Baker FA Rating Sa ars - 12 ye	cale	O 2 No Hurts Little Bit	(©) 4 Hurts Little More	6 Hurts Even More	8 10 Hurts Whole Lot No	Numerical Rating Scale (age moderate) 1 2 3 4 5 6 Mild Moderate	7 8	9 10
Observa	cal care F tion Tool tor / com	(CPOT)	COMPLIANCE WITH VE	Absence of m NTILATION (I ubated paties lelaxed, 1 - Te	novements or normal ntubated patients): 0 nts): 0 - Talking on no nse, Rigid, 2 - Very Te	cosition, 1 - Protection, 2 - Restlessno - Tolerating Ventilator or Movement, rmal tone or no sound, 1 - Sighing, M rnse, Rigid	1 - Coughing but tolerating, 2 - Fighting v	ventilator (or)	-
Non-pi	harmacol tervention	ogical Is	Cutaneous Stimulation a Thermal Theraples (no to	nd massage onger than 15	: E - Positioning; F - R to 20 minutes): G - C	- Music; D - Physical and mental exc ubbing / Massage the skin old application; H - Hot application; I erferntial therapy Psycho-social t		eling; L - Family	ocounseling
Pharmac	ological i	ntervention	s as per doctor's prescrip	tion					

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71/Malc/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ



MHI/NUR/2022/052



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.
14.00	1/10	Aus poin	200 Væ	Offeren	Pharmadagical Managamont deno	Chair to the	600)
16.00	1/10	dull-prin	to-15	back	Non formaldogical managament done	Clark Coth	A ODD)
18.00	1/10	dull-poèn	CIF Obse	Sack	Canfortable position given.	Obus Oak	(Jour)
lo-00	160	Achy Palen	210 Sec	Storunun	uon_plannacological Information done	05 FD	Low
JJ-00	1/4	Dull peur		ergrap	Confortable position	00%	Ross
30/12		Patient	1 0	e glapt	- wou	2000	000
<u> </u>		Patro	Ut_	ű el	ept well	35	1
84-00		Patter	t	U Sce	pt usoll.	0760	200
6-00	Leo		A QDC	suighal eite		S S	لعدوق

	•					,-										
Dáte & Time	Pain Score	(dull, achy,	sharp,	haracter stabbing, sho ed / radiant pa	ooting, ain)	Duration	Location / Site		Interventions					aff Initial Emp. No.	Initi	r Staff ial & . No.
8.00	1/10	d	ull	paln		210	Afaracoas	phannaulogica	l Mondonnon	t d	logie	,	0	hus of A	RV	2007
10-00	1/10		de 10	patr		ClF Obs	back	Confortable	fonttian	<u>4</u> 11	юn.		(laul Coota	$\Delta_{\mathcal{O}}$	D)
(h;20	©/10	بح.	00	pin		y 1	_	0	V 	Ü			(L)	DIN	Nas Da	9- 14
H8 500		^	90 (pion										om!	No	<i>ع</i>
							P/	AIN SCALES						,		
(28 week	PIPP\$ s to <u><</u> 38	weeks)	7 - 12	ess = Minima ! = Mild pain = Moderate to	- Provid	le comfort me	easures nocological interventi	on								
(38 we	CRIES eks - 2 me	onths)						s of gestation. A maximal sco gesic administration is indica				core Is	> 4,			
	ACC Scal							erate discomfort, 7-10: Sever								
	-Baker FA Rating Sc		(0)			(§)		(A) (A)	Numerical	Rating	Sca	le (age	more	than 12	+	4
	ırs - 12 ye		N H	O F	2 turts	4 Hurts Little More	6 Hurts Even More	8 · 10 Hurts Whole Lot Worst	None Mild	^	1	5 Moderate		Y B	yere	10 ^
Observa	cal care F tion Tool tor / com	(CPOT)	BODY COM: VOCA MUSC	Y MOVEMEN' PLIANCE WI ALIZATION (r CLE TENSIO	TS: 0 - TH VEN non-Inti N: 0 - R	Absence of m NTILATION (II Libated paties Lelaxed, 1 - Te	ntubated patients): (position, 1 - Protection, 2 - Res 0 - Tolerating Ventilator or Move ormal tone or no sound, 1 - Sig ense, Rigid	ement , 1 - Coughing b				ing venti	ilator (or)		
	armacolo ervention		Cutar Therr	neous Stimui nai Therapie:	i <mark>ation</mark> a s (no lo	nd massage: nger than 15	: E - Positioning; F - F to 20 minutes): G - C	C - Music; D - Physical and mer lubbing / Massage the skin old application; H - Hot applica terferntial therapy Psycho-s	ation; I - Shortwave dia	thermy	- Indiv	idual Co	unseling	յ; L - Famil	/ counse	oling
Pharmace	ological l	ntervention	s as pe	er doctor's p	rescrip	tion				ı						

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71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ



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.
92,00		Dull pain	one	Surgical Site	Phasimalological intervention Given	Hay	Nove
3(1/20) A:50	40	· Dull pain	>10Sec	Surgical Site Fore head	Phaemecological Entelvention Given	form	, ,
6:00	1/10	Deell pain	on2 588	Suegical Bite	Non-Phaemacological Interestion Given		Na0-
16.0	1/10	DOLL	ong opp	Swajial Sild	Non- pharmatelogiaes		Nas
Le-00	Ilo.	Dull pain	on El	Surgical Sule	Non Phannacologo al shilesention given	SOR	News
		Dull pair	on Ep	Sugical Sete	von phaema cological interest ar gruen	Soyle	News
	_	Dull Pain			Phaemaeological intervention Given	Hay	Nas
					Patient is skeping		720
6100	Yw	Dull pain	ONL OB	Suegical Site	Non-Pherenaeological intervention Given	How	282

Date & Time	Pain Score	(dull, achy,	ain Character sharp, stabbing, shooting, , referred / radiant pain)	Duration	Location / Site		Intervention	s		Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
10.00	0/10	Νl	o pain	-	<u> </u>					Adn	Pagy
11/20		N	pin	_	_	~				John	Nos
Bed	allo	. N	io pain.	<u>.</u>						(P)	Not
22.00	060		we pain	_						025	Nag.
	1.1	,		•	PA	IN SCALES	•				
(28 week	PIPPS (s to <u><</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	le comfort me		חס				· ·	
(38 we	CRIES eks - 2 m	onths)				of gestation. A maximal sco jesic administration is indica				<u>-</u>	,
	ACC Sca		0: Relaxed & comfortable	e, 1-3: Mild di	iscomfort, 4-6: Mode	rate discomfort, 7-10: Sever	e discomfort / pa	ain / both			
Wong Paln	-Baker FA Rating Se ars - 12 ye	cale	O 2 No Hurts Little Bit	4 Hurts Little More	6 Hurts Evan More	8 10 Hurts Worst	Numeri 0 1	Pating 2 3	Scale (age moderate	7 8	years) 9 10
Observa (ventila	cal care F Itlon Tool Itlor / com	(CPOT)	COMPLIANCE WITH VE	Absence of m NTILATION (III ubated patier Relaxed, 1 - Te	novements or normal p ntubated patients): 0 nts): 0 - Talking on no nse, Rigid, 2 - Very Te	position, 1 - Protection, 2 - Res - Tolerating Ventilator or Move rmal tone or no sound, 1 - Sigl nse, Rigid	ement , 1 - Cougl	ning but toler		ventilator (or)	
	harmacolo		Cutaneous Stimulation a Thermal Theraples (no lo	ind massage: onger than 15	E - Positioning; F - R to 20 minutes): G - Co	- Music; D - Physical and mer ubbing / Massage the skin old application; H - Hot applica erferntial therapy Psycho-s	ation; I - Shortwa	ve diathermy ounselling: K	Individual Couns	eling; L - Famil	counseling .
Pharmac	ological i	ntervention	s as per doctor's prescrip	tion							





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Dr.ANBARASU MOHANRAJ

MHI/NUR/2022/052-



		- / 10 0 2 0 0 111 2 1 1 1			VIII 11 11 11 11 11 11 11 11 11 11 11 11	_	
Date & Time	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.
2.00	6 M	No pain		_		O281	Nac.
p.60	e Cio	No pain	_			OH!	Naca-
10-00	0/10	No pain	-	-	· · · · · · · · · · · · · · · · · · ·	Joyn	Nac
			-				
				•			

Date & Time	Pain Score	duli, achy	ain Cha sharp, sta , referred	racter abbing, sho radiant pa	ooting, ain)	Duration	Location / Sit	e		Inter	ventio	ns					Staff In & Emp.	ıtıaı	Senior Initial Emp.	1 &
**															•				· 	_
_											,									
	1									_	,			·			· 		·	
	 					13 13 13					/									
<i>)</i> !	-							PAIN SC	ALES		_	-		-		•				
} 28 week	PIPPS (s to <u><</u> 38	weeks)	7 - 12 =	s ≈ Minima Mild pain Moderate to	- Provid	le comfort me	easures nocological interve	ntion			_				•				_	
(38 we	CRIES eks - 2 m	onths)					than or = 38 wee								core is	> 4,			_	
	ACC Sca nths - 7 y		0: Rela	ed & comi	fortable	e, 1-3: Mild d	lscomfort, 4-6: Mo	derate disc	omfort, 7-10:	Severe disco	omfort / j	pain / b	oth	_			-			
Pain	-Baker F <i>i</i> Rating S ars - 12 y	cale	(©) 0 ≥ H		2 furts title Bit	4 Hurts Little More	6 Hurts Even More	8 Hurts Whole Lot	10 Hurts Worst	C A	Ĺ	rical F	Rating 3	4	e (age	6	re than	12 y	9 1	10
Observa	cal care i ition Tool itor / com	(CPOT)	BODY N COMPL VOCAL MUSCL	MOVEMEN' IANCE WI' IZATION (r E TENSIOI	TS: 0 TH VEN non-inti N: 0 - R	Absence of m NTILATION (I ubated patler relaxed, 1 - Te	eutral, 1 - Tense, 2 - novements or norm ntubated patlents nts): 0 - Talking on ense, Rigid, 2 - Very loderate Pain; 5 - 8	al position, '): 0 - Tolerati normal tone ' Tense, Rigid	ng Ventilator o or no sound, ' t	r Movement,	1 - Coug	ghing b				ling ve	ntilator (or)		
	harmacol tervention		Distract Cutane	lon: A - Re ous Stimul	laxatior	n-conducive e	environment; B - TV : E - Positioning; F to 20 minutes): G	; C - Music; - Rubbing / I	D - Physical ar Massage the sl	kin		ave diat	hermy							



71/Malc/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj





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

ASS	ign a score of 1 if (4ES) in parameter nos. 1 to 9,	ลกน สรร	nyli a sci	016 01 -2	11 (163)	ııı paraı	netel IIO	. 10
	Date	27/12	28/12/					
	Time	121-00	7-00					
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	Ø	0					
2	Bedridden recently >3 days or major surgery within four weeks	0	0					
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	<i>\O</i>	0					
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	, D	0	-				
5	Entire leg swollen (Assess for both legs)	0	0					
6	Localized tenderness along the deep venous system (Assess for both legs)	<u></u>	0					
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	P	0					
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0					
9	Previously documented DVT (Assess for both legs)	0	0					
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	6	0					
	FINAL SCORE	6	0					
Low R	tisk: -2 to 0 Moderate Risk; 1 to 2 High Risk: 3 to 8	Qu.	Low					
	DVT prophylaxis started	☐ Yes ☐ No	☐ Yes ☐ No	□ Yes □ No	☐ Yes ☐ No	☐ Yes ☐ No	□ Yes □ No	☐ Yes ☐ No
	Signature & Emp. No. of RN	₩	1					
≱ •	Signature & Emp. No. of Sr. RN	(V)	(P)					
		67	65					



Patient [Mr.KALIYAN S 71/Mulc/MHI202381394 27/12/2023/IPH2023002614 Name: UHID: Dr.ANBARASU MOHANRAJ DOB: DOA:



: Consultant

	DVI RISK AS							
Ass							- 	
	-	Date 18 D 29						
_	T	13-00	06/00	P 6-001	6:00	6200	prour	
S. No.	PARAMETERS	 '	 '	 	 '	<u> </u> '	 	
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0	0	0	6	
2	Bedridden recently >3 days or major surgery within four weeks	+)	-+1	41	41	+1	+1	
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0	O	0	Q	
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	1 _ i	0	Ð	0	,0	D	
5	Entire leg swollen (Assess for both legs)		0	0	0	0	0	
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0	0	0	0	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0		0	0	D	
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)		0	Ð	0	0	 ' 	
9	Previously documented DVT (Assess for both legs)	0	0	0	0	0	0	
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.		0	O	O	0	0	
	FINAL SCORE	71	+1	+1	1+1	H !	1-	
Low R	Risk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8		mon (mon	<u></u>	1	Moo	
	DVT prophylaxis started		∑ √Yes	U Yes ⊤	☐ Yes ☑ No	□ Yes □ No	□ Yes □ No	☐Yes
	Signature & Emp. No. of RN	Stanto	THE STATE OF THE S	品	Hows	Hery	POT !	1
	Signature & Emp. No. of Sr. RN			1		200	امرول ا	



(A Unit of United Alliance Healthcare Pvt Ltd)



Mr.KALIYAN S

71/Male/MHI202381394 27/12/2023/IPH2023002614

di.anbarasu mohanraj



MODIFIED MORSE FALL RISK ASSESSMENT CHART

	Date	23/12	27-12							
Variables	Time	1	200					-		
History of falling	No	0	9	0	0	0	0	0	0	0
(immediate or within 6 months)	Yes	25 .	25	25	25	25	25	25	25	25
Secondary diagnosis	No	0	٥	0	0	0	0	0	0	0
(≥ 2 medical diagnosis)	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy /	No	0	0	0	0	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID				-					·	
None / Bed Rest / Nurse Assist	l	_8_	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	a	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, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No Yes	150	0 145	0	0 15	0 15	0 15	0 15	0 15	0 15
Total Score		15	30							
Low Risk (0 - 24)		600			\					
Medium Risk (25 - 44)		_ 👯	,_		_				-	
High Risk (45 or above)		_								
Signature & Emp. No. of RN		980	Telp				_			
Signature & Emp. No. of Sr. RN			(10 /							
		-03	24: Low	Risk; 2	5 - 44: N	/ledium	Risk; 45	or abo	ve: High	n Risk

	_		١.			ĺ			,	
INTERVENTIONS	Date	2=1/11	07/2	<u></u>				 		<u> </u>
Tick as per the Risk Score	Time		20.00	l .						
Low Risk Interventions (0 - 24)		। १/1-छ	200		-					
Familiarize the patient with the immediate surround	lings			r	}				ĺ	
Remind the patient to use call bell before getting ou				<u> </u>	 -	-			 - -	
Keep the two side rails in the raised position at all t		<i>//</i>			 				 	
all patients regardless of age		. " /	レレ	<u>r</u>	ľ				1	
Keep the call bell, bedside table, water, glasses w	ithin the			_	-				<u> </u>	
patient's easy reach		/	\ \]				
Remove excess equipment or furniture to make	a clear									
path		<u> </u>	/ /	1	-					
Keep the patient's bed in the low position at all times	sexcept									
during procedure	•	<u> </u>					,		-	
Teach fall-prevention techniques, such as sitting	up for a	/		ŀ	1				ļ ·	
moment before rising from the bed			r V	٠ .			<u></u>	ļ 	ļ	
Bed wheels should be locked					 					
Encourage family participation in the patient's care					<u> </u>	<u> </u>				
Ensure that floor of the bathroom is dry and not slipp Review medications for potential side effects the				<u>.</u> ;	<u> </u>			-	 	<u> </u>
promote falls	nat can	/	1 、/	ļ, -	ĺ			-		
Use safety belts during movement in wheelchair	_	<i>v</i>	/ -			 .	 			
The patients are not ambulated by themselves. The	ev are to				[<u> </u>	
be ambulated only with assistance	y are to		\ <u>\</u>	ļ		1	-			
Medium risk interventions (25 - 44)						<u> </u>		-		
Apply all the low risk interventions		·		<u>"</u>			-			
Tie yellow fall risk tag in the bed and Wheel chair / St	tretcher	-								-
Make sure that proper transfer precautions are in								_		•
for heavy or debilitated patients in a bed or wheel		ļ	~	· ·	!		·			
on a toilet seat		1				•	•	-		
Use restraints and bed monitors as ordered by the o	doctor		/	[-
Allow the patient to ambulate only with assistance										
Consider peak effects of the medications that effects		İ			1				1	
of consciousness, gait and elimination when p	lanning	i .		,	,					
patient's care		 			 	 			ļ ,	
Do not leave patients unattended in diagnot treatment areas	ostic or		/	[1	
Accompany the patient while going to bathroom						 				
Advice the patient to use grab bars near the toilet, t	nathtuh	 			1	<u> </u>				
and shower	- mir tidley			r .	1					
Make sure the family and other visitors underst	and the		 			 				
restrictions mentioned above			: 🗸	Γ.	}					
High-risk interventions (45 or abovc)			À	7	-				 -	
Apply all the low and medium risk interventions		<u> </u>	I VX			· .			e .	
Tie red fall risk tag in the bed, wheel chair and stretc										
Locate the high-risk patients in a room close to the	nurses'				1				}	
station		<u> </u>							<u> </u>	
Answer these patients call bells as quickly as possit	ole	ļ								
Provide a commode at bedside (if appropriate)	anglete)					<u> </u>				
Urinal/bedpan should be within easy reach (if appro Encourage family members or other visitors to s		 			<u> </u>	<u> </u>			 	\vdash
them	idy Willi							•	'	
If appropriate, consider using protection devices	: safety	 	 		-		_,		 	
belts	. caloty				-					
Signature & Emp. No.	of RN	421/	(M)	-	-		,	- 7		
	-	# \	~~()		<u> </u>	<u> </u>				
Signature & Emp. No. of S	or KN	₩				<u> </u>	L., .		<u> </u>	
			102							
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Medway Hospitals[®]

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



Mr.KALIYAN S

Pai 71/Malc/MHI202381394 Nai 27/12/2023/IPH2023002614

UH DI.ANBARASU MOHANRAJ



MHI/NUR/2022/046

MODIFIED MORSE FALL RISK ASSESSMENT CHART

	,		_ \							
Variables	Date	38/2/3	23/12	2012	39/12	29/12/3	30/12	Po/18/12	3912/12	31/12/
Variables	Time	12.00	19:30	₹.0°	12.00	70.00	8.60	31,20	$\mathfrak{D}_{i_{\mathcal{Q}_o}}$	هم
History of falling	No	0	(1)	.0	J 8	(0)	8	0/	0/	9
(immediate or within 6 months)	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis	No	0	0	0	0	0	0	0	0	0
(≥ 2 medical diagnosis)	Yes	(15)	(15)	15	15	(15)	15	15	15	15
Intravenous Therapy /	No	<u> </u>	0	0	0	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	(60)	20	28	20	(20)	20	20	20	20
AMBULATORY AID							/			
None / Bed Rest / Nurse Assist		(0)	(0)	,0	10	(O)	<i>,</i> 0⁄	æ	20	vo
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT		0					/	-	, ,	
Normal / Bed Rest / Wheel Chair		<u>(6)</u>	(6)	9	√0	(0)	,0	9	10	9
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		6	(O)	D	ø	(6)	_ کھی_	9	0	9/
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics	No Yes	o (15)	0	0 , 15	0	0 (15)	0	0 15	0	0 45
and psychotropics										
Total Score		50	50	.60	Б 0	50	315	رم ال	50	BO
Low Risk (0 - 24)			•		'					
Medium Risk (25 - 44)										
High Risk (45 or above)		✓ .	·/		/	V			~	/
Signature & Emp. No. of RN		#	27	٤٤٤	(Mary)	製豆	Sur Si	An Com	tay	90°
Signature & Emp. No. of Sr. RN		1	7		d.	L	/ L	W	124	اركونا
		_0007-2	24: Low	Risk; 2	5 - 44-N	ledium	Risk; 45	or abo	ve: High	Risk
		77		41.1	~//	A - /	- 77	7.7		

INTERVENTIONS Tick as per the Risk Score Time 2.0 OW Risk Interventions (0 - 24) Tamiliarize the patient with the immediate surroundings Remind the patient to use call bell before getting out of bed Geep the two side rails in the raised position at all times for all patients regardless of age Geep the call bell, bedside table, water, glasses within the patient's easy reach Remove excess equipment or furniture to make a clear path Geep the patient's bed in the low position at all times except during procedure Freach 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 be ambulated only with assistance Meditur risk interventions The patients are not ambulated by themselves. They are to be ambulated only with assistance Meditur risk interventions The patients are not ambulated by themselves are instituted or heavy or debilitated patients in a bed or wheel chair or on a toilet seat Jee 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 batient's care Do not leave patients unattended in diagnostic or reatment areas Accompany the patient to use grab bars near the toilet, bathtub, and shower Advice the patient to use grab bars near the toilet, bathtub, and shower Advice the patient to use grab bars near the toilet, bathtub, and shower Apply all the low and medium risk interventions The red fall risk tag in the bed, wheel chair and stretcher Occase 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)	7 19:3	2.0° 2.0° 2.0° 2.1 2.1 2.1 2.1 2.1 2.1 2.1 2.1 2.1 2.1	1 / / / / / / / / / / / / / / / / / / /	21-00	30 N2 8:00 1 1 1 1	ngol land	200	
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station Answer these patients call bells as quickly as possible	1					 _		
Answer these patients call bells as quickly as possible w		7 . /						
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	-/_	/			<u> </u>		
Provide a commode at bedside (if appropriate)	7.	1/	/					
	$\overline{}$	1/	1/_	<u> </u>		 		
Jrinal/bedpan should be within easy reach (if appropriate)	NA	 	<u> </u>	M		 	/_	"/-
Encourage family members or other visitors to stay with	- NB	'/					//	f h
hem f appropriate, consider using protection devices: safety		1./	/		<u> </u>	+-		
r appropriate, consider using protection devices: safety pelts	1 /		/	m				/
Α	/ /	ans	ווכל ציוו מ	al	18(110)	W. Co	1000	8.7
Signature & Emp. No. of RN Signature & Emp. No. of Sr. RN	401	100	Marcon 1	12	ZMXQ.	070°		96V





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



Mr.KALIYAN S

71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ





MHI/NUR/2022/046

Where heart beat never stops...

MODIFIED MORSE FALL RISK ASSESSMENT CHART

		1		}	1.100	1 \ 09			1	1
Variables	Date	31/12	3/1/2/27)	111/24	I_{II}	11/2	2/1/2	1		
·	Time	14.00	25/08	800	Helias	2-0,00	8			
History of falling	No	0_/	50	10	9	9	9/	0	0	0
(immediate or within 6 months)	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis	No	0	0	0	0_	0	0	, 0	0	0
(≥ 2 medical diagnosis)	Yes	15⁄	15/	15	V 15	15	15	15	15	15
Intravenous Therapy /	No	0	ŏ	0	0	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	20	20	20	<i>-2</i> 6	20	20	20	20	20
AMBULATORY AID		_					7	,		
None / Bed Rest / Nurse Assist		0	10		18	(O)	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					_			1		
Normal / Bed Rest / Wheel Chair		0 <	10	10	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		,o /	0_	0	0/	o	10.	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS	-									
Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives,	No	0	. 0	o	0	o	o	. 0	0	0
immunosuppresent, anticonvulsants,	Yes	15	15	115	15/	<i>†</i> 5	15/	15	15	15
anti-hypertensives, hypoglycemics and psychotropics					7					
Total Score		50	50	50	60	50	مر			
Low Risk (0 - 24)		, <u></u>			-* /		5			
Medium Risk (25 - 44)										
High Risk (45 or above)		/ 』		W						
Signature & Emp. No. of RN		Red	Herry	MILL	ma jul	Q v	160/			
Signature & Emp. No. of Sr. RN		120	1924	حُقِيًّ	New	199	124			
,		<u> </u>	24: Low	Risk; 2	5 - 44: N	ledium	Risk; 45	or abo	ve: High	Risk
· · · · · · · · · · · · · · · · · · ·										

INTERVENTIONS	Date	21/12	21/12/62	1 1 212	1/24	11/21	2/1/2	7		- 1
Tick as per the Risk Score	Time	14.00	30,500	2.00	12/20	20.00	هر په			
Low Risk Interventions (0 - 24)		14. 1/V	/	X 100	10	¥)	1		-
Familiarize the patient with the immediate surround	dinoe		\ <u> </u>	1	~			ļ		
Remind the patient to use call bell before getting ou			~/		-					
Keep the two side rails in the raised position at all			ļ <u> </u>	 					 	
all patients regardless of age	umes ioi	_	k /		ر ہ		h /		1	
Keep the call bell, bedside table, water, glasses w	uithin the		-	 		-/			 	-
patient's easy reach	ritinii tiite		/				1/	ľ		ļ l
Remove excess equipment or furniture to make	a clear			 				2		-
path	, a cicui				5			L	ł	
Keep the patient's bed in the low position at all time	s excent			├				<u> </u>		
during procedure	3 CACCPI	_						_		
Teach fall-prevention techniques, such as sitting	up for a		<u> </u>	 				<u> </u>		
moment before rising from the bed	up ioi a		//	├		$ \vee\rangle$	_ /			
Bed wheels should be locked			-			1		-	 	
Encourage family participation in the patient's care	 _		- /				, 		 	-
Ensure that floor of the bathroom is dry and not slip			√ /	-		/			 -	
Review medications for potential side effects 1		-	-/-	 	_		- (
promote falls	mat can		/				//	Ĺ		
<u></u>								<u></u>		
Use safety belts during movement in wheelchair		/_	· /	\succeq			- 			
The patients are not ambulated by themselves. Th	ey are to			\	_		· /			
be ambulated only with assistance		//	`				/		ţ	1
Medium risk interventions (25 - 44)									İ	
Apply all the low risk interventions	14		<u> </u>		·	\bigvee		·		
Tie yellow fall risk tag in the bed and Wheel chair / S		4	-			\rightarrow		 		<u> </u>
Make sure that proper transfer precautions are in						, 'V	,	l l		
for heavy or debilitated patients in a bed or wheel	chair or		/			l. / l		<u> </u> ,		
on a toilet seat		0	-	 	7/		-//			<u></u>
Use restraints and bed monitors as ordered by the		/	ļ.,—,				<u> </u>	ſ		
Allow the patient to ambulate only with assistance		0/							<u> </u>	
Consider peak effects of the medications that effe]			/ /)		
of consciousness, gait and elimination when p	planning			\sim						
patient's care				<u> </u>			· ,	_	<u> </u>	
Do not leave patients unattended in diagno	ostic or		_				_ /			
treatment areas							<u> </u>	<u></u>	_	
Accompany the patient while going to bathroom		/	<u> </u>		V	V		 -	_	
Advice the patient to use grab bars near the toilet,	bathtub,			\		, [ľ		
and shower			0		V		_ /		<u> </u>	
Make sure the family and other visitors underst	tand the		· .			l . 📝	n /			
restrictions mentioned above				~			/			
High-risk interventions (45 or abovc)			1	<u> </u>		1				
Apply all the low and medium risk interventions						/				
Tie red fall risk tag in the bed, wheel chair and streto			/				_'_	<u> </u>	<u> </u>	
Locate the high-risk patients in a room close to the	e nurses'		/	\		 、/	h ' /			
station	:	 						<u> </u>	<u> </u>	<u> </u>
Answer these patients call bells as quickly as possi	ble	1			/				<u></u>	
Provide a commode at bedside (if appropriate)		_	/			<u>/</u>	/	<u> </u>	ļ	
Urinal/bedpan should be within easy reach (if appr										
Encourage family members or other visitors to s	stay with	_ آ	· /		,	ا <i>آ</i> کا]
them	<u> </u>	ļ								ļ
If appropriate, consider using protection device	s: safety	/				. /	/]	
belts	<u></u>				1			/	<u> </u>	
Signature & Emp. No.	of RN	100A	Harte	J WL	1800	(P)	>/0%V	Y	[]
		12 N	1	1 100 P	7	<u> </u>	C/1/20	<u> </u>	 -	┝─┤
Signature & Emp. No. of	Sr. RN	K 4 1	يميكو	100.50	7	_حي	عبوك	<u> </u>	<u> </u>	<u> </u>







Mr.KALIYAN S

71/Malc/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ





PATIENT AND FAMILY EDUCATION RECORD

Assessment To be						plines. L								
Barriers to	Le	arning						,		Plan t	o A	ddr	es	s Factors
None		Vision	/ He	earin	g lir	nitations	5			Use	of Ir	nterp	rete	er -
Limited Reading Abilities		Physic	cal b	arrie	rs] Edu	cate	fam	ily	
Religious / Cultural Factors		Langu	age	barr	iers					Sim	ple l	.ang	uag	e
Congnitive Limitations - unable to		Low m	otiv	atior	1 / d	esire to	learı	1	Γ	Writ	ten l	Instu	ctio	ens
understand and follow directions														
Completed By : Date <u>) オ にって</u>	ne_	12.	<u>3</u> -	<u> </u>	Nurs	se Signa	ture	:_		<u>Fred</u>	1	_	_	
				0 ×	\delta \									
Learning Record		ı	T											
Need		Date		Visit	: 1	Date	_\	/isit	2	Date	e Vi		3	Signature
		23/h	Ĺ	Р	0	28/12	上	Р	0		ᆚ	Р	0	
Disease														Doctor
Information on														andon
Disease / Diagnostics			b	ഹ	حلا									Us
Treatment			Ö	08	ט									
Medications			O	b82	ن (Doctor / Nurse
☐ Information on Safe and			ľ		l									
Effective use of medicines			p	bb.	v									
☐ Information on drug / drug and														
drug / food interactions			'n	200	V									
☐ Discharge Medications														
Surgical instructions														Nurse
Pre- Operative Instructions			D	DD.	V									3
Post - Operative Instructions			<u> </u> '				'							
(Wound / Dressing Care)		ļ												
Pain Management									Щ				Ц	Nurse
Reporting of pain	_		p	20	V								Ц	Nac
Pain Management			P	Ď	<u>/</u>									24
Safe and effective use of medica	ıl		ľ											Doctor / Nurse
Equipment (if required)			_						Ш				Ц	
Name of Equipment														
Rehabilitation Techniques													ı	

eed	Date	١	Visit	1	Date	١	/isit	2	Date	١	/isit	3	Signat	ture .
	27/12	L,	Р	0	2 Mar	┖	Р	0	30/12	FL	Р	0		
lutritional Guidance	ľ											П	Dieticia	n .
Diet Instruction for patients at Nutritional risk		P	8	>		Q	ο•Ω			P	08	V	8)	176
Diet advice for home		•	-	Ш		l	1	-					Nurse	
Discharge Planning														
] Self care														
Follow up														
Reporting Concerns Immunizations														
Parenting education			†										_	
Others												H	<u> </u>	
Risk Factor Reduction						Т		 		 	 	H		
Smoking Cessation :						•			. ~.			П	Doctor	
☐ Weight Control			\vdash					\vdash				П		
 │ Hypertension					-									
Other Risks		\vdash												
EARNER (L) - P-Patient, M - Moth PROCESS (P)- OD - Oral Discussion OUTCOME (O) - RD - Return Demo Vritten Material given and explain	on, D- Dem Instration,	ons	trati	on,	W- Wr	itter	n Ma	iter	ial					nship)
PROCESS (P)- OD - Oral Discussion	on, D- Dem Instration,	ons	trati	on,	W- Wr	itter	n Ma	iter	ial			_		
PROCESS (P)- OD - Oral Discussion OUTCOME (O) - RD - Return Demo	on, D- Dem Instration,	ons	trati	on,	W- Wr	itter	n Ma	iter	ial					
PROCESS (P)- OD - Oral Discussion OUTCOME (O) - RD - Return Demo	on, D- Dem Instration,	ons	trati	on,	W- Wr	itter	n Ma	iter	ial					
PROCESS (P)- OD - Oral Discussion OUTCOME (O) - RD - Return Demo	on, D- Dem Instration,	ons	trati	on,	W- Wr	itter	n Ma	iter	ial					
PROCESS (P)- OD - Oral Discussion DUTCOME (O) - RD - Return Demo	on, D- Dem instration, ed (if any)	ons	Verb	on,	W- Wr	itter / ders	n Ma	iter	ial			ndir	ng N/	
PROCESS (P)- OD - Oral Discussion OUTCOME (O) - RD - Return Demo Vritten Material given and explain Reports Given : Given Pen	on, D- Dem	ons	Verb	on,	W- Wr	itter/	1 Ma	iter	ial g			ndir	ng N/	
PROCESS (P)- OD - Oral Discussion OUTCOME (O) - RD - Return Demo Vritten Material given and explain Reports Given : Given Pen Discharge Summary	on, D- Dem	ons	Verb	on,	W- Wr	eport	1 Ma	iter	ial g			ndir	ng N/	
PROCESS (P)- OD - Oral Discussion OUTCOME (O) - RD - Return Demo Vritten Material given and explain Reports Given : Given Pen Discharge Summary	on, D- Dem	ons	Verb	on, paliz	W- Wr	eport	1 Ma	iter	ial g			ndir	ng N/	
PROCESS (P)- OD - Oral Discussion OUTCOME (O) - RD - Return Demo Vitten Material given and explain Reports Given : Given Pen Discharge Summary ECG Report Doppler Report X-Ray Report	on, D- Dem	ons	trati	On, paliz	Advice Scan Fil	eport	n Ma	iter	ial g			ndir	ng N/	
PROCESS (P)- OD - Oral Discussion OUTCOME (O) - RD - Return Demo Vritten Material given and explain Reports Given : Given Pen Discharge Summary ECG Report Doppler Report	on, D- Dem	ons	trati	On, paliz	W- Wr	eport m ort Rep	n Ma	iter	ial g			ndir	ng N/	









Assessment To be filled by concerned disciplines. Use key below Barriers to Learning Plan to Address Factors														
Barriers to	, i 													s Factors
None		Vision	/ He	aring	g lin	nitations	3		V	Use	of lr	nterp	rete	
Limited Reading Abilities		Physic	al b	arrie	rs				L	Edu	cate	fam	ily	
Religious / Cultural Factors		Langu	age	barri	ers				Ш	Sim	ple I	_ang	uag	e
Congnitive Limitations - unable to		Low m	otiv	ation	/ d	esire to	learr	1		Writ	ten l	Instu	ıctic	ons
understand and follow directions														
Completed By : Date 28 12 3 Tim	:_	la offe												
Learning Record														
Need		Date	\ 	/isit	1	Date	\ \	/isit	2	Date	\ \	Visit	: 3	Signature
		28/2	L	Р	0	29/12	L	Р	0	30/12_	ī.	P	o	
Disease					٠,٠									Doctor
Information on														1,00
Disease / Diagnostics			ᢒ			.			_		_	را م	1 4	(8)
Treatment			B	വര	V		2	က	レン		7	005	1/2	(34)-
Medications	İ		S	or	\	1		60			X.		19	Doctor / Nurse
Information on Safe and														Qu
Effective use of medicines			S	0b	V		૭	OD	V		n.	e/	,	7
☐ Information on drug / drug and		•									_		Γ	4
drug / food interactions			g	මත	V				-					
☐ Discharge Medications						_			1					
Surgical Instructions														Nurse (V)
☐ Pre - Operative Instructions			-			_	J							
Post - Operative Instructions														
(Wound / Dressing Care)			S	<i>0</i> 0	\	<u> </u>	8	OC			ဂ	<u> </u>	15	
Pain Management	Management										,	9		Nurse (
Reporting of pain						Ş	വ	\checkmark		7	9	9	- Carrier	
Pain Management		Q	S	1	,	_	nΩ				2 (1)	0		
Safe and effective use of medica	u -							···			7,			Doctor / Nurse
Equipment (if required)			Ü	9	>		PT	DD	V					
Name of Equipment					_									
Rehabilitation Techniques							0	hΩ	VΙ					

leed	Date		Visit	1	Date	\ \	/isit	2	Òate	1	/isit	 : 3	Τ	Signature
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utritional Guidance	128	T	T	\vdash	20/12	\vdash		H	-			Ī	+-	Dietician
Diet Instruction for patients at Nutritional risk		h	91 >	V		P	δD	✓		b	عد	Ś	7ā; Sē	nio, Sie Coulon
Diet advice for home		<	+-	-	_			Ħ	- 	-	-	F	┷	lurse
ischarge Planning		İ	1										T	
] Self care	 		+	┝				H					t	
Follow up		-	-	 									1	
Reporting Concerns Immunizations		,												
Parenting education	<u> </u>	·				┢─		H			\vdash		\dagger	
☐ Others		\vdash	+	t		\vdash		H				T	+	
isk Factor Reduction			7	 		\vdash		Н			<u> </u>	T	T	
Smoking Cessation	 	Τ.		 	, , , ,	T			494 July 1			T	10	octor
] Weight Control		ſ	\top	T		\vdash		П	,-			T	T	
Exercise	1	T				<u> </u>		П			T	T	T	
1 Hypertension		F	1										十	•
Other Risks EARNER (L) - P-Patient, M - Mother, ROCESS (P)- OD - Oral Discussion, UTCOME (O) - RD - Return Demons	D- Dem tration,	ons	strati	ion,	W- Wri	itter					(Sta	ite	Relationsh
Other Risks EARNER (L) - P-Patient, M - Mother, PROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons	D- Dem tration,	ons	strati	ion,	W- Wri	itter					(Sta	ate	Relationsh
Other Risks LEARNER (L) - P-Patient, M - Mother, PROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Written Material given and explained	D- Dem tration,	ons	strati	ion,	W- Wri	itter					(i	Sta	ate	Relationsh
Other Risks EARNER (L) - P-Patient, M - Mother, PROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Vritten Material given and explained	D- Dem tration, (if any)	V -	strati	ion,	W- Wri	itter								
Other Risks EARNER (L) - P-Patient, M - Mother, ROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demonstritten Material given and explained	D- Dem tration, (if any)	ons	Verk	ion,	W- Wri	ders				1	Per			
Other Risks EARNER (L) - P-Patient, M - Mother, ROCESS (P)- OD - Oral Discussion, UTCOME (O) - RD - Return Demonstricten Material given and explained	D- Dem tration, (if any)	V -	Verk	ion,	W- Wri	ders				1				
Other Risks ARNER (L) - P-Patient, M - Mother, OCESS (P)- OD - Oral Discussion, ITCOME (O) - RD - Return Demonstitten Material given and explained All ports Given : Given Pendingscharge Summary	D- Dem tration, (if any)	V -	Verb	ion,	W- Wri	itter	tand			1				
Other Risks ARNER (L) - P-Patient, M - Mother, OCESS (P)- OD - Oral Discussion, ITCOME (O) - RD - Return Demons itten Material given and explained Output Figure 1: Given Pending Scharge Summary CG Report	D- Dem tration, (if any)	V -	Verk	Diet	W- Writed Unc	itter	tand							
Other Risks EARNER (L) - P-Patient, M - Mother, ROCESS (P)- OD - Oral Discussion, JTCOME (O) - RD - Return Demonstritten Material given and explained Peports Given: Given Pending ischarge Summary CG Report Oppler Report	D- Dem tration, (if any)	V -	Verk	Diet	W- Writed Und	port m	tand			1 —				
Other Risks EARNER (L) - P-Patient, M - Mother, ROCESS (P)- OD - Oral Discussion, UTCOME (O) - RD - Return Demons Initten Material given and explained Completed Summary CG Report Coppler Report C-Ray Report	D- Dem tration, (if any)	V -	Verb	Diet	Advice Scan Re Scan Fil	port	tano							
Other Risks EARNER (L) - P-Patient, M - Mother, ROCESS (P)- OD - Oral Discussion, UTCOME (O) - RD - Return Demons Iritten Material given and explained Open Pendin Oischarge Summary CG Report Ooppler Report	D- Dem tration, (if any)	V -	Verk	Diet	Advice Scan Re	port m Rep	ort			1 —				

-







Mr.KALIYAN S

71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj



Assessment To be f	AND F									OR	D			_
Barriers to					-	-36 R				o A	ddr	es	s Factors]
None	☐ Visi	on / H	earin	ıg lir	nitations			ĪF	Use	of l	nterp	rete		1
Limited Reading Abilities	Phy	sical I	barrie	ers] Edu	cate	fam	ily		1
Religious / Cultural Factors	Lan	guage	barı	riers					Sim	pie L	ang	uag	e	1
Congnitive Limitations - unable to	Low	moti	vatio	n / d	esire to	learı	n] Writ	ten i	instu	ctio	ns	1,
understand and follow directions				_								_		1
Completed By : Date 3110 Tim	ne <u>-8</u> -	کریک		Nurs	se Signa	iture	, <u>S</u>	50						1
<u> </u>								-	.1					
Learning Record					<u> </u>				г				<u> </u>	· T)
Need	Dat	e L	Visi	_	Date	<u> </u>	Visit		Date	<u>\</u>	/isit	_	Signature	-
	3/1	ᆚ上	P	0	1121	٢	P	0	D/MIN	Ľ	Р	0		}
Disease		\bot	\bot	$oldsymbol{oldsymbol{\perp}}$		_		$oxed{oxed}$			_	<u> </u>	Doctor	
☐ Information on													11.82	
Disease / Diagnostics		\bot	↓	$oldsymbol{ol}}}}}}}}}}}}}}}}}}$		P	a	γ		Q	50	V	12455	ß
Treatment		q		b			╙			Ľ		Ц		ľ
Medications		1,02	Or			P	\Box	V		8	ъ£	∠	Doctor / Nurse	
Information on Safe and		ľ					l			"			, 9 - ,	
Effective use of medicines		┸	$oxed{oxed}$	L		P	\square	٧		p	<i>5</i> 5	$oxed{}$	OG 9	١
Information on drug / drug and							1		l					K
drug / food interactions						P	0	y		Ø	200	S		
☐ Discharge Medications														
Surgical Instructions													Nurse	
Pre - Operative Instructions			Т										HUNGS	1
Post - Operative Instructions			I^{-}											1
(Wound / Dressing Care)						P	(D)	V		p	000			
Pain Management		\top	Τ	T		Ť		Ť		۳			Nurse	1
Reporting of pain		\top	1	T		P	Ø	ν		P	700	,,	Nuc	1
Pain Management		T	\top			P	9			<i>B</i>	20	, ,	024	1
Safe and effective use of medica	<u> </u>	1	\dagger	T		Ι'	<u> </u>	Ť		=	۳	Г	Doctor / Nurse	1
Equipment (if required)														
Name of Equipment														1
Rehabilitation Techniques														1

Nutritional Guidance Diet Instruction for patients at Nutritional Fish	Need	Date	V	/isit	1	Date	١	/isit	2	Date	\	/isit	3	Signatur
Nutritional Guidance Diet Instruction for patients at Nutritional frisk Diet advice for home Diethory		23/12	L	Р	0	Ed/IR	L	Р	0	281.	L	Р	0	
Diet advice for home	Nutritional Guidance													Dietician
Diet advice for home Discharge Planning Disch	Diet Instruction for patients at		O	00	W									Maria Call
Discharge Planning Self care Follow up Reporting Concerns Immunizations Parenting education Others Risk Factor Reduction Smoking Cessation Weight Control Exercise Hypertension Other Risks LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other PROCESS (P) - OD - Ogal 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 Discharge Summary Diet Advice ECG Report CT Scan Report Doppler Report X-Ray Report L-Ray Film Ultrasound Report Ultrasound Report	Nutritional risk			<u> </u>	Ĺ		P	\circ_{ν}	Ľ	_			<u>ر</u> ب	Senior Dictivio
Self care Follow up Pollow up Parenting Concerns Immunization Others Risk Factor Reduction Smoking Cessation Weight Control Exercise Hypertension Other Risks LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other PROCESS (P)- OD - Ogal 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 Discharge Summary Discharge Summary Discharge Summary CT Scan Report Doppler Report CT Scan Report CT Scan Report Ultrasound Report Ultrasound Report Ultrasound Report	Diet advice for home						<u> </u>	<u> </u>			3	š	2	Nurse
Reporting Concerns	Discharge Planning										۵	_Ω	J	
Reporting Concerns	<u> </u>													Nuan
Parenting education	Follow up				L						7	$\overline{\omega}$	Ы	
Others Risk Factor Reduction Doctor Smoking Cessation Doctor Weight Control Exercise Hypertension Other Risks LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other Common Cess (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 :										,				
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Smoking Cessation □ Weight Control □ Exercise □ Hypertension □ Other Risks LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other □ (State Relations) PROCESS (P)- OD - Orar Discussion, D- Demonstration, W- Written Material OUTCOME (O) - RD - Return Demonstration, V - Verbalized Understanding Written Material given and explained (if any) Reports Given: □ Given Pending NA Given Pending NA Discharge Summary □ Diet Advice ECG Report □ CT Scan Report Doppler Report □ CT Scan Film X-Ray Report □ CT Scan Film X-Ray Report □ Ultrasound Report Ultrasound Report Ultrasound Report	Others										-		П	
Weight Control Exercise Hypertension Other Risks LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other (State Relations) 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 :	Risk Factor Reduction												П	
Exercise Hypertension Other Risks LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other (State Relations 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	☐ Smoking Cessation	,											П	Doctor
Hypertension Other Risks	☐ Weight Control												П	
Other Risks LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other (State Relations PROCESS (P) - OD - Ogal 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	☐ Exercise												П	
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Reports Given Pending NA Given Pending NA Discharge Summary Discharge Summary Discharge Summary CT Scan Report Doppler Report X-Ray Report X-Ray Film V-Doppler Report (State Relations) State Relations (State Relations) State Relations (State Relations) (State Relations) (State Relations) (State Relations) (State Relations) (State Relations)	Other Risks	-1 4,		_									П	_
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Discharge Summary ECG Report Doppler Report X-Ray Report CT Scan Report CT Scan Film ECHO Report Ultrasound Report Ultrasound Report	Reports Given :													
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ECG Report CT Scan Report Doppler Report CT Scan Film X-Ray Report ECHO Report X-Ray Film Ultrasound Report	Discharge Summary	7)		_ [Diet	Advice								<u> </u>
Doppler Report CT Scan Film X-Ray Report ECHO Report X-Ray Film Ultrasound Report				_ (CT S	Scan Re	porf	t	,		_			
X-Ray Report ECHO Report		/					-		1		_			
X-Ray Film Ultrasound Report	··· .									_	_			
	<u> </u>					-		n ===			_			
Compact Disk Any Other Report	•	<i></i> _/					•							
<u> </u>	Compact Disk		$\overline{}$	_ ^	чпу	Other F	cepc	pπ						
	Name of Attendant / Patient :_			<i></i>				Sig	nat	ure :				
Name of Discharge Nurse Signature :				7				_			-			



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

Mr.KALIYAN S

71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj



Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 24(12)23	Time: 2	3.00	<u> </u>				
Checklist	Yes	No	NA	Ac	tion / Remarks		
MEDICAL				-			
Daily Consultant Visit		T					
Plan of care discussed							
Discharge Planning	· X						
Others if any	7						_
NURSING				_			
Safety Precautions Ensured							
Care of Lines and Tubes	1						
Infection Control Measures	1						
Skin Care							
Response to assistance							
Others if any	X						
DIETICIAN							
Diet Adequate			<u> </u>				
Special Request							
PHYSIOTHERAPIST							
Available for Assistance for Activities of Daily Living							
Others if any			<u> </u>				
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						_	
		lr	nter Dis	sciplinary Team Members			
	Signatur		·	Name	Reg. / Emp. No.	Date	Time
Doctor	<u> </u>	<u></u>		Dr. Sin Elaypo	179044	27/12/23	[ጿ. ው
Nursing Staff		- <u> </u>		B. Vanisa	0195	2मीर्घ ५	13.00
Dietician Physiotherapist		Alu	<u> </u>	Maria Catherine John Senior Dietitism AKASH- G.E	2401	22 fully	10.50
Patient Care Service Staff	(JB·	PHON	-	HKUZH. QI.E	02.5b	28/12/23	12750
rations care Service Stall					L	1	



Patient I Mr. KALIYAN S

Name: 71/Malc/MHI202381394

UHID:

27/12/2023/fPH2023002614

DOB: DOA:

Dr.ANBARASU MOHANRAJ





IN-HOUSE TRANSFER FORM

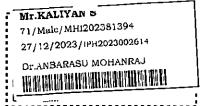
	·											
Part	Part A (to be filled by Nurses)											
Date	e of Transfer: 30 12 5) <u> </u>	<u>1:30</u> Tra	ansferred f	from: <u>9</u>	D_2co	<u> 7</u> +	LECR (10A)				
Diag	gnosis:	- TVD .										
Vital	Signs: Temp: <u>पुन-न</u> (°F) Pulse / HR:	96	(beats/m	nin) BP: <u>] 6</u> 5	≒6(10) mmHg) Respi	iration:	(breaths/min)				
art	B (to be filled by Phy	ysicians) p	Any Critica	al Investig	ations:	- 						
	Check for			Trar	nsferring Docto	or		Receiving Doctor				
Resp	piratory (Breath sounds)	Clear	Crepitati	ion R	thonchi 🗌 Ot	thers:		Yes No				
Abdo	omen	Soft	Tender	D	oistended 🗌 Ot	thers:		Yes No				
Hear	ں t Sound	Normal [Feeble	E Loud	Others:_	=======================================		Yes No				
CNS		Consciou	ıs Or	riented	GCS Sco	re:		Yes No				
	Surgical Patients plicable)	Surgical Site:	Heal	thy S	oakage O	thers:		Yes No				
		Preser	nt Medic	ation (for	Medication Re	econciliation)						
S. No.	Current Medic	ation	Dose	Route	Frequency	Date & Time of last dose		continued during hospital stay				
	TAB - FRUSEI	m IDE	Langort	Plo	1-1-0	30/12/23 at 8:00	[]	⊠Ýes □ No				
٤,	_					30/12/23 07 10.00	J	☑Yes ☐ No				
8	NEB-LEVOL	` ` ` `	0-62ma	' i`	0,6thly	30/12/230 9.35	<u></u>	ZYes □ No				
P.	syp- sucrnit	THE_	Comi	Plo	1-1-1	30/12/23 at 7.40	ال ا	☑Yes ☐ No				
5	MAR BEPLEX	FORTE	17713	Plo	1-0-0	30/12/23/18:05	ل	☑Yes 🗌 No				
b,	TAB - CLOPILET.	-Aspiral	1575	Plo	0-1-0	29/12/23d 14.00	ل	Z Yes ☐ No				
4	TAB-ATORY	ACTAPTIN	Fromus	Pho	0-0-1	34/12/03/2 2100	<u>ٽ</u>	☑ Yes ☐ No				
8	TAB. PARACE	TAMOL	PZDVa	Plo	1-1-1	30/12/23 01 8.05		✓ Yes □ No				
9,	OND COSTAMBLE	EIN PLUS	Isml	Plo	0-0-1	29/12/23 08 9:00		✓Yes □ No				
(D)	THE METOP	20101	(2-2UM	e Pho	1-0-1	30/12/23 0/ 9.15	-	Yes 🗆 No				
							[☐ Yes ☐ No				
	<u></u>						[☐ Yes ☐ No				
							[☐ Yes ☐ No				
					t ,			☐ Yes ☐ No				
			<u> </u>					☐ Yes ☐ No				

Additional De	tails (if any):					
							ì
							-
	_						
Patient Condi		Stable	Sick-need urgent care Other		1 = 1		
Transferring	Sign		Name	Reg. No.	Date	-	Time
Doctor		<u> </u>	Dr. Pravaen	112236	30/	12/23	10.30
Receiving Doctor		K.80-	Dr. K. Amusuys	139555	31	12/23	10740
Part C (to be t	filled	by Nurses)					
Check for			Transferring Nurse				ng Nurse
Drains			bdominal Others:			Yes	No No
Respiratory		Air Way Type: Oxygen Therapy		s:li/m	in	☐ Yes	S No
NG Tube / Oral		Yes No	For Feeding Gastric Suction	Fluid Restriction		Yes	i 🗌 No
Foley's Catheter	r	Yes No		-		Yes	No No
Intravenous Acc	ess	Peripheral Li	ne Central Venous Line Others	<u> </u>		Yes	No No
Pressure Injury		Yes No	If Yes, give details:			Yes	
Score		Fall Risk: 35				Yes	No No
Patient Belongir	ngs	· ·	If Yes, give details:		_	Yes	No
Handover Detail	ls		inistration Record explained: Yes C Reports handed over: Yes N			Yes	Nc Nc
Patient Attendar Informed	nt	Yes No	If No, give details:			Yes	s 🗌 No
Additional De	tails (if any):					
	Sign		Name	Emp. No.	Date	!	Time
Transferring Nurse	Q	ul?	Oloma Florantis	00-14	30	12 23	p·30
Receiving Nurse		Por	Ganna Florances parithrs	0072-	2012	187	Jot No

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FAMILY COUNSELLING FORM

CONSU		2- ANBAR	DIAGNOSIS- CAD -TV D.		-	
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
20/12/2	AEFFH2,G	Goderin.	ondition and 200 portions and moutment plan.	~	S. Charact	الدداء
34/2/23	2002 H	C. C. P. P. P. P. P. P. V.	Explained about the gameral condition, Mood of 100 lb viritor's foliop.	-	4 March	H123



Patient Details (Affix Label here)

Name: HR - KALLYAN
UHID: 714[M 20288139



2772 25 23002 bil Every heart beat counts

WOUND ASSESSMENT CHART

DATE	2/1/22			_			
SITE OF WOUND							
CHEST							
LEG L/R							
ABDOMEN			<u> </u>			<u> </u>	
SACRAL REGION							
HEEL							
OTHERS							
SIZE OF THE WOUND							
SUPERFICIAL / DEEP IN NATURE					/		
PRESSURE Specify system used :					,		
RISK FACTORS Specify system used :	DM	HTN	Age	Obesity			
WOUND TISSUE TYPE(S) PRESENT							
necrotic							
slough							
undermining							
granulation							_
overgranulation							
epithelialisation		, 🗆					
other							₽-
SURROUNDING SKIN TISSUE TYPE(S) macerated							
erythema							
oedematous							_
cellulitis							
blistered							
bruising							_
dry / scaling							
healthy	6						

WOUND ASSESSMENT CHART

EXUDATE AMOUNT		Ī										
none												
evidence of some moisture	-											
evidence of significant flow												
EXUDATE												
serous												
sero - sanguinous												
Purulent												
ODOUR												
none												
some evidence of odour												
significantly malodorous												
PAIN AT WOUND SITE	.1											
(nil) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (max)	0/0											
INFECTION SUSPECTED*												
SWAB SENT												
ANTIBIOTIC THERAPHY												
BLOOD GLUCOSE / URINE ANALYSIS												
PATIENT / CARER TO DO DRESSING												
SIGNATURE	logn											
*SIGNS & SYMPTOMS OF WOUND INFECTION: Pytexia excess exudate *SUSPECT WOUND INFECTION IF: Ilicalised pain pus granulation tissue bleeds easily healing is slower than anticipated												
● erythema offensive	odour	F 1	gile bridge o	fepithelium	occurs 🍎 🖔	wound brea	kdown					







Every heart beat counts

VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME:

Mr.KALIYAN S

71/Malc/MHI202381394 27/12/2023/PH2023002614

AGE / SEX:

Dr.Anbarasu mohanraj

IP No. / UHID No

Ward / Bed No.

Sico _ BED D

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

		Airi	OOO!\L	0 01.0025				
DATE	TIME	SITE	SCORE	DESCRIP	TION	ACTION	FOLLOW UP	S / N EMP No.
,	, ,	_		¥.			-	ı
28/12/18	13-00		0/5	DV HINE	AFF WI	Capputa	OB SERVATION	20
-	19130	RILLYT CUBITAL	0/2	POTSNT	160cah	FWAHED	NO SILVE OF PHISBITIS	Bono
	7.00	Rabibl	05	1V (840	protecul	= leeshal	MOSIGN'S OF PHLEB	TIS CAUSTOCA
2/12	12.00	(Rubifal	OF	IV line	poteal	Flushool	NO SIGNS OF PIKES	nu Opina
31/,	21-00	DMETA	0/5	PATEN		FLIGHED	OBOFIZVATION	SOPN
	8.00	@uchoczy	ago bear	IN BERRY	polarit	Flushal	ADDGNS OF PHLE	BITUS April 5
30/12	13/20	no tray	0/8	Evel Stree	pulat	flushood		Polal
	30;o		ol5	Pat	ent	flreshed)	Hay
	8-10	P. Alestrope	Pls	pat	erf	Hushed		an
3/12/12	14.00	pt motala		Pal	ent	fleee	-	Bel
	90;co	Metacan	los	_ Past	ent	Husha		House
	8.00	metaccipal	0/5	Par	fe _r t	Shieland	Ĺ	Pooln
ililati	chilo	refuciple	0/5	puker	nt_	Thished		wh!
l .	20.0		0/5	parei	4	Firsted	-	D02+,
1/0×1	8.00	ptomotocand	ols	Per	feet	fold		podla
				, Oine	Pan	sed		
◇ \			4		•			
								·



Drug Chart:__

108



Mr.KALIYAN S

71/Malc/MHI202381394 27/12/2023/IPH2023002614

DT.ANBARASU MOHANRAJ

Height (cms): 1620m

MHI/PHARM/2022/028



Every heart beat counts

Weight (kg): <u>63</u>

MEDICATION ADMINISTRATION RECORD

		KNO	NN MEDICINE	ALLERGIE	S (if NC	ONE is co	onfirmed,	write NKDA in	box 1)			
Drug Di	etalis		—,,—,,—,,—,,—,,—,,—,,—,,—,,—,,—,,—,,—,,	Descri	otion of	Allergy			Doct	or's Sign:		
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[]	осто	R INSTRU	CTIONS			NU	RSING S	TAFF INSTRUC	CTIONS)
2. Write i 3. Sign a 4. No pre	n BLOCK nd enter escription	LETTERS, c MCI registrat		2. Nurse 3. For ne follow 4. Stand Q8hdy	in-charge aw prescrip standard ard Timing : 06:00hrs, ars, 17:00h	should ver ption, follow timings gs: Q24hrly 14:00hrs, 2 rs, 23:00hrs	w the timing: : 10:00hrs, Q :22:00hrs or 0 :, Q4hrly: 02:	art on daily basis s of doctor's presc 12hrly: 10:00hrs, 22 9:00hrs, 14:00hrs, 3 00hrs, 06:00hrs, 10:	2:00hrs or 0 21:00hrs, Q	6:00hrs, 18:00h 6hrly: 05:00hrs,	nrs,	
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To be filled by Nursing Staff only. Sign and time given Date → REGULAR PRESCRIPTIONS 29/12/00/12/ To be filled in by Doctors only Time 🖟 DRUG NAME 06.00 TM. PARACETAMOL Dose Route Frequency 08thm 12m 14:00 52.4 Start Date & Time Dr. Sign & Rec. No / Seal Dr. PRAVEEN JEYAKUMAR 00-410 812 21 RC 14.00 Reg. No:112236 Stop Date & Time 29/12/21 at 10.00 200-66 Additional Info: DRUG NAME 071:30 SYP-SUCRALEATE SUSPENSION Dose Route Frequency Clinical Pharmacist Modway Heart Institute 13:30 26 1-1-1 Lami Start Date & Time 28 12 23@ 30 30 19:30 ·Reg. No:112236 Stop Date & Time Ø Additional Info: Oh'reo 5.00 DRUG HAME A-00 NEB · LEVOLAL RUTAMO Frequency Cumbal effections to Modinal Heart Institution Dose Route 10.00 Q 6th holy 0.68 mg 2NH Or Sign & Hea No / Seal Start Date & Time (7-QC 22/12/301700 14.00 Reg. No:112236 Stop Date & Time O) Additional Info: ab)-00 9,00 ج. ههٔ DRUG NAME 8,00 TEB- FRUSEIDIDE Dose Route Frequency <u>40003</u> 1-1-0 /ν<u>જ</u> ত Dr. Sign & Reg No / Sealmar Start Date & Time blot 29/12/23 AT 8.00 16,00 Q% Reg. No:112236 Stop Date & Time <u>ھ</u> Additional Info: **DRUG NAME** \0`° 10,00 TAB. SPIRAMOLAUDHE Dose Route Frequency Clinical Pharmacist Lifedway Heart Institute 1-10 25 mg (XZ Dr. Sign Preveenpje Preumar Start Date & Time 4.04 29/11/23 AT 10:00 Reg. No:112236 17:00 (C)¢ Stop Date & Time لم Additional Info: Area In-charge Murse Signature:

Clinical Pharmacist

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Clinical Pharmacist Medway Heart Institute

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REGU	LAR PRESCRI	PTIONS	Date →		_		ing Sta	ff only.	Sign ar	nd time	giv
To be	filled in by Docto	ors only	Time ↓	2912	30/12/8	31/12/12	illey	2/1/2	,	-	
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	MARIDE		4.00				Hay				
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Dr. Sign & Reg. I	No. / Seal	Start Date & Time	-								-
		Stop Date & Time				-					-
Additional Info:											
Area In-charge Nurse Signatur	e:			∅ ,	(d)	No.	8/4	62/			

To be filled by Nursing Staff only. Sign and time given Date → ANTIMICROBIALS To be filled in by Doctors only Time **↓ DRUG NAME** 5.15 IN CEEPEDXIME SODIUM Dose Route Frequency Distributy <u>၊ 5ခွက</u> Start Date & Time <u> वेक्षायय भा प्राप्त</u> 17.15 Reg. No:112236 Stop Date & Time 29/12/2 at 18.15 Additional Info: **DRUG NAME** Dose Route Frequency Dr. Sign & Reg. No. / Seal Start Date & Time Stop Date & Time Additional Info: **DRUG NAME** Dose Route Frequency Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: DRUG NAME Route Frequency Dose Dr. Sign & Reg. No. / Seal Start Date & Time Stop Date & Time Additional Info: DRUG NAME Route Frequency Dose Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: Area In-charge Nurse Signature:

Clinical Pharmacist

		<u> </u>		Data (Additive Drug			Do	ctor	Adn	ninistratio	n
Date	Time	Intravenous Fluid	Volume	Rate / Duration	Route	Name	Dose	Range		Reg. No.		,	
				dam1-									Jan ou
38/17/23	12:45	KABIWIE	500ml	lamilwo	J.				8	11256	- ` ` ` ` ` 	16.00	
8/12/2	16.00	CABILLYTE	Cooml	nomilia	DV.			- 1	ع	11236	16.00	21:00	OZ
eeleslee	<u>%1;00</u>	KABILYTE	GOOML	(00 metyr	ιV	,	-	~	8	112216	21:00	00:00	
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<u>स्ताव श</u>	11.30	CHRIENTE -	MOIDML	(PD 1811 1+112							11.00	1 30	10 2.16
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CHEST	, -		PARENTI	ERAL INFL	JSION F	RESCRIPTION AND ADM	INISTRA	TION	RECO	RD			
D-10	Times	Intravenous	Volume	Rate /		Additive Drug			Do	ctor	Adn	ninistratio	n /
Date	Time	Fluid	volume	Duration	Route	Name `	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.
Q& 12122	12,45	NS 0194.	25m	amily	IN	INT MITPOUNTEUMF	d5mg	<u>-</u>	8-	112236	12.45	23:00	Jany
2/12/3	16.00	NS 0.9%	40 mz	201HR	IV_	anj. H-ACIRAPID	4022		۶	112236	16.00		Se les
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DIET ORDERS	(to be prescribed t	by Doctors only)
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Date	Time	Dlet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
28/12/2	13-00	Wpo	6.	112236			7		
09/12/23	8.00	LIQUID DET	8	112236				<u> </u>	
30(2/23		SOFT DIET	1 k.Br	134459					
31/12/23	,	coff diel-	11.80	184459					
1/1124	8:00	Normal del-	11.80	13459					
2/1/27	600	Normal diel-	1.B	134450					-

NURSE IDENTIFICATION RECORD

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

	·	(to be entered by all the	nuises involve	su iii auii	minster	ing mould	cations pressribed in the charty		
Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning	·			1/1/280	Morning	Pavishea	00 \$ 2	Pall
28/12/2	Evening	SHEEBA . D	0240	d de la composition della composition della comp	1/1/28.	Evening	U. Doutlo	10th	2
28/0/23	Night	Jux onyo.Co	0223	Que	1 2	Night	A. Nancthini	0172	A
39 12123	Morning	D. PANEER	0131	Danis	2/12	Morning	10. Lidera	0249	Seal
29/12/22	Evening	GENTA TLORANCES	00-f4	Hair	2/1/24	Evening	Dangmegnois	9333	W
مرادافه	Night	SHEEDD. D	0270	1	,	Night			
20/12/22	Morning	ORNIA FLORANCE'S	10×4	Saur		Morning			
30/12h	Evening	el Dovilar	06	O	 	Evening			}
30/11/2	Night	Harriah asale	005	Host		Night			Acres de la constante de la co
alph	Morning	4. Deile	OYL	&		Morning			<u> </u>
31/12/	Evening	0. Daujos	32249	Real		Evening			
3/112/02	, Might	Hannahlisale	over	Hay		Night	-,		



Drug Chart:_

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of



Mr. KALIYAN S 71/Malc/MHi202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj

Height (cms):_

MHI/PHARM/2022/028



Every heart beat counts

MEDICATION ADMINISTRATION RECORD

			KNOWN MEDICINE A	LLERGIE	ES (if NO	ONE is c	onfirmed,	write NKDA ii	•		
Dru	g De	etails		Descri	ption of a	Allergy			Doct	or's Sign: 🗲	logo
			MILOA						Nam	e: Dr.Si No. 179	i Eby
					_	,			Reg.	No. 179	044
	C	OCTO	RINSTRUCTIONS			NU	RSING S	TAFF INSTRU	CTIONS	-	
2. W 3. Si 4. N	/rite i ign a o pre	n BLOCK nd enter escription	me when prescribing drug LETTERS, clearly and legibly MCI registration no. or apply seal should be altered / overwritten mat when writing time	2. Nurse 3. For ne follow 4. Stand Q8hrly	in-charge w prescrip standard ard Timing :: 06:00hrs,	should ve otion, follow timings gs: Q24hrly 14:00hrs, 2	w the timing: : 10:00hrs, Q 22:00hrs or 0	omissions art on daily basis s of doctor's preso 12hrly: 10:00hrs, 22 9:00hrs, 14:00hrs, 2 00hrs, 06:00hrs, 10:	2:00hrs or 0 21:00hrs, Q	06:00hrs, 1 8 :00h 6hrly: 05:00hrs,	nrs,
			Stat /	Once O	nly / P	remed	ication	Drugs			
Dat	te	Time	Drug		Dose	Route	Sign.	Poctor Reg. No.	Sign.	Administere Emp. No.	d Time
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28	12	5.00	T. ALP RAX.		0.5	Pb	go	15302	D	0170	5.00
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			Date →	To b-	fillod L	ne Mire-	ing St-	off only	Sign s	nd tim -	aluse
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Dose	Route	Frequency	gro on		Nb						
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DRUG NAME	T. GTHI COR	R ITPATE									
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Dr. Sign & Reg.	No. / Seal	Start Date & Time									
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Additional Info:	T- METZOR			~~~~~ >/@	· · ·			;			
Dose	Route	Frequency /	C:00m		Npo		4 ;	•			
Dr. Sign & Reg.	No. / Seal	Start Date & Time									
Additional Info:			Stip of 2m								
DRUG NAME	7-3 KAT							}		<u>-</u>	
Dose 1 tab	Route P/6	Frequency	Q room		VP						
Dr. Sign & Reg.	No. / Seal	Start Date & Time Stop Date & Time									
Additional Info:	_	<u></u>		<u> </u>		ļ <u>.</u> .					
Area In-charge Nurse Signatur		 			3/4						

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			DIET ORDERS	(to be pro	escribe	d by Doctor	rs only)	_	
Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
astr	Rom	NPO from 12AN	200	18570	-				
						N RECORD			
		(to be entered by all t	he nurses invol	ved in adn	ninister	ing medicat	tions prescribed in the chart)		
Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
del 47	Evening	A. Nardhini	0110	A		Evening			

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
رطور المحرو	Evening	A. Mandhini	0140	A		Evening			
D8 0 12	Night	1. Nardhini	0170	A		Night			
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	Mr.KALIYAN S 71/Malc/MHi202381394 27/12/2023/IPH2023002614		,		М	HI/ICU/2022/076
Name	Dr.Anbarasu mohanraj		- I			Sheet No.
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Blood Gr	oup	Height		Weight	BSA	Δ
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SURGICAL PROCEDURE:

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

DATE OF SURGERY: 28/12/23

POST-OP DAY: Dos

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		VENTILATORS PARAMETERS												BLOOD	GAS		
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	12.45 14.00 15.00 16.50	12.45 PS 12.00 PS CAN 14.00 PS CAN 16.00 PS CAN 16.00 PS	TIME MODE RATE 31	TIME MODE RATE SUPPORT 2.45 Ps	TIME MODE RATE PRESS PEAK PRESS 21	TIME MODE RATE PRESS PEAK PEEP 31 mu	TIME MODE RATE SUPPORT PRESS PEAK PEEP MEAN PRESS 12.45 P3	TIME MODE RATE PRESS PEAK PRESS MV 21	TIME MODE RATE PRESS PEAK PRESS PEEP MEAN MV ITV 12.45	TIME MODE RATE SUPPORT PRESS PEEP MEAN MV ITV ETV 12.45	TIME	TIME MODE RATE SUPPORT PRESS PEAK PEEP MEAN PRESS MV ITV ETV FIQ. 31 mu	TIME MODE RATE PRESS PEAK PRESS PEEP MEAN MV ITV ETV FIO. PH 31 mu	TIME MODE RATE PRESS PEEP MEAN MV ITV ETV FIQ PH PCQ PA PRESS PEEP PRESS MV ITV ETV FIQ PH PCQ PH PCQ PS PS ILL 16 18:0 5:0 7:6 500 499 50 7:43 39.45 14-00 59 12 16 21-0 5:0 6.5 500 450 50% 7:398 49.0 16.00 499 12 12 5.0 5:0 5:0 5:0 5:0 5:0 5:0 5:0 5:0 5:0 5:	TIME NODE RATE PRESS PEEP PRESS MV ITV ETV FIO. PH PCO. PO. 12.45 PS 14 16 18.0 5.0 7.6 500 4.79 50 3.43 32.45 183.5 14.00 15.00 12 16 21.0 5.0 6.5 500 450 50% 15.00 16.00	TIME MODE RATE SPRESS PEEP MESS MV ITV ETV FIO. PH PCO. PO. HCO. 12.415 PS	TIME MODE RATE PRESS PEAK PRESS PEEP MEAN MV ITV ETV FIO. pH PCO. PO. HCO. SAT% 2.45 PA

PATIENT HAD RELEIVED FROM OT: 12.45

OT URINE: 650ml

NEURO

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

VERBAL

Oriented-5 Confused/Disoriented-4 Inappropriate words-3 Sounds-2 No response-1

MOTOR

Br-Brisk

SI-Sluggish

O-Absent

Obey commands-6 Localise pain-5 Non-localising-4 Abn.Flexion-3 Abn.Extension-2 No response/flacid-1

CAPILLARY REFILL

MOTOR ARMS/LEGS

S-Strong Wk-Weak O-Absent A-Anasthesia CP-Chemical paralysis

PUPILS SCALE (mm)

•		•
1	2	3 4
•		
	5	6
	7	8

PUPILS REACTION

Br-Brisk	
SI-Sluggish	1
O-Absent	

CARDIOVASCULAR

D-Dependent

G-Generalised

EDEMA

O-Absent

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

NECK VEINS

JVP N-Normal In-Increased

VALVE CLICK/ SHUNT NUMBER

Valve Replaced / Shunt +Present O-Absent

PULMONARY

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

BREATH SOUNDS	SECRETIONS	CHARACTER
CL-Clear Ro-Ronchi Wh-Wheezes CR-Crackles BECL-Bilat equal & clear	COLOUR CL-Clear Y-Yellow W-White Pk-Pink	M-Moderate Sc-Scanty Th-Thin Tk-Thick Cs-Copious R-Red

GASTROINTESTINAL

BOWEL	SOUNDS
+Present	

+Present O-Absent

ABDOMINAL TONE

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

LIVERSIZE

N-Normal E-Enlarged

NGT POSITION

Air injected +Heard in Abd O-Absent

GA-Gastric contents aspirated Dr-Dependent Drainage

GASTRIC RESIDUAL

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







7	Ir.KALIYAN S 1/Malc/MHI20	2381394	\			M	IHI/ICU/2022/076
Ni D	7/12/2023/IP) Dr.ANBARASU A			Ą	je	Sex	Sheet No.
Blood	Group	POSITIVE_	Height		Weight bB⊭ผ	BSA lebsm²	Α

SURGICA	AL PR	OCEDURE:					DA	TE OF S	SURGERY	1: 28H	2/23		PC	ST-OP [DAY: _g	عور
				VENTIL	ATORS	PAF	RAMET	TERS				[BLOOD	GAS	
~																

						VENTIL	ATORS P	ARAMET	ERS			<u> </u>			BLOOD	GAS			
DATE	TIME	MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ίτν	ETV	FíO₂		рН	PCO ₂	PO₂	HCO,	SAT%	BE	
20/10/02	23.00	On	NAS	De_	Pron	ررد					4676								
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	<u> </u>										<u> </u>		_		_				
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NEURO

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

VERBAL

Oriented-5 Confused/Disoriented-4 Inappropriate words-3 Sounds-2 No response-1

MOTOR

Obey commands-6 Localise pain-5 Non-localising-4 Abn.Flexion-3 Abn.Extension-2 No response/flacid-1

CAPILLARY REFILL

MOTOR ARMS/LEGS

S-Strong Wk-Weak O-Absent A-Anasthesia CP-Chemical paralysis

PUPILS SCALE (mm)

•		
1	2	3 4
	5	6
	7	8

PUPILS REACTION

Br-Brisk SI-Sluggish O-Absent

CARDIOVASCULAR

•	(500)((
HE	ART SOUNDS
S1	S2
M-N	/lurmur

M-Murmur Rb-Rub G-Gallop

Br-Brisk

SI-Sluggish

O-Absent

SM-Sound muffled

EDEMA

D-Dependent G-Generalised O-Absent

NECK VEINS

JVP N-Normal In-Increased

VALVE CLICK/ SHUNT NUMBER

Valve Replaced / Shunt

+Present O-Absent

PULMONARY

WORK OF BREATHING

Ab-Abdominal TA-Thoraco-abdomial

L-Laboured

SUCTION

ET-Endotracheal N-Nasal

or-Oral

BREATH SOUNDS

CL-Clear Ro-Ronchi Wh-Wheezes CR-Crackles BECL-Bilat equal & clear

SECRETIONS COLOUR CL-Clear Y-Yellow W-White Pk-Pink

M-Moderate Sc-Scanty Th-Thin Tk-Thick Cs-Copious R-Red

GASTROINTESTINAL

BOWEL SOUNDS

+Present O-Absent

NGT POSITION

Air injected +Heard in Abd O-Absent

GA-Gastric contents aspirated Dr-Dependent Drainage

ABDOMINAL TONE

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

GASTRIC RESIDUAL

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

LIVERSIZE

N-Normal E-Enlarged OPCAB X 3 QRAFIS

LIHA — 7 LAD

SVQ — 7 CH

SVQ — 7 CH

SVQ — 7 CH

Medway Hospitals®

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



Mr.KALIYAN S 71/Male/MHI202381394]	_	M	HI/ICU/2022/076
N 27/12/2023/IPH2023002614 Dr.ANBARASU MOHANRAJ]	-	. · -	Sheet No.
	,	Age	Sex	(3)
Blood Group O POSITIVE	Height	Weight	BSA libkm²	Α

-- 1

DATE OF SURGERY: 28/12/23 POST-OP DAY: 1 POD SURGICAL PROCEDURE: **VENTILATORS PARAMETERS BLOOD GAS** DATE TIME PRESS SUPPORT PEAK MEAN MODE RATE PEEP MV ſΤV **ETV** FíO₂ PCO, PO₂ HCO, SAT% ΒE pН PRESS PRESS ROOM ON AIR CRITICAL CARE FLOWCHART

NEURO

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

VERBAL

Oriented-5 Confused/Disoriented-4 Inappropriate words-3 Sounds-2 No response-1

MOTOR

Br-Brisk

Si Singgieh

Obey commands-6 Localise pain-5 Non-localising-4 Abn.Flexion-3 Abn.Extension-2 No response/flacid-1

CAPILLARY REFILL

MOTOR ARMS/LEGS

S-Strong Wk-Weak O-Absent A-Anasthesia CP-Chemical paralysis

PUPILS SCALE (mm)

•		
1	2	3 4
	5	6
	7	8

PUPILS REACTION

Br-Brisk
SI-Sluggish
O-Absent

CARDIOVASCULAR

D-Dependent

G Conordised

EDEMA

O-Absent	O-Absent	
HEART SOUNDS S1 S2	NECK VEINS	VALVE CLICK/ SHUNT NUMBER
M-Murmur Rb-Rub G-Gallop	N-Normal In-Increased	Valve Replaced / Shunt +Present
SM-Sound muffled		O-Absent

PULMONARY

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

BREATH SOUNDS	SECRETIONS	CHARACTER
CL-Clear Ro-Ronchi	COLOUR	M-Moderate
Wh-Wheezes CR-Crackles	CL-Clear Y-Yellow	Sc-Scanty Th-Thin
BECL-Bilat	W-White Pk-Pink	Tk-Thick Cs-Copious
equal & clear		R-Red

GASTROINTESTINAL

BOWEL SOUNDS	NGT POSITION
+Present O-Absent	Air injected +Heard in Abd O-Absent GA-Gastric contents aspirated Dr-Dependent Drainage
ADDOMINAL TONE	

ABDOMINAL TONE So-Soft GASTRIC RESIDUAL

D-Distented

LIVERSIZE N-Normal E-Enlarged

F-Firm	G-Green	B-Bleeding
Tn-Tender	Y-Yellow	C-Coffee ground
Ob-Obese		

Mr.KALIYAN S

Sheet No.

В

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71/Malc/MHI202381394

27/	2/2023/1442023002614	
	NBARASU MOHANRAJ	

Name		LARNAHOM UZAR		_		
UHID No.	-		_	(A	ge	Sex
Blood Gro	ир 🔘	POSITIVE	Height		Weight	BSA





MHI/ICU/2022/076



				ВІОСНІ	MISTRY			VITAL PARAMETERS								CARDI	AC ASSIST	DEVICE	
DATE	TIME	Hb	Na	K	Ca SUGAR	BLOOD	TIME	ETCO ₂	BREATH SOUNDS	Sao ₂	RR/MT	N,BP	TEMP°F	Abd ^{c™} G	TIME	IABP RATIO	DURATION	ľ	R SETTING MODE
28/pl23	12.SD	13.9	133	14:41	1.07		โลเมธ		CL		PHIME	,	967				DEIGHION	WIL.	MODE
							1 <u>%</u> -60		CL	100%	14/ht								
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28/12/18	4,50	14,0	135	4,27	1:00		18-00	<u> </u>			14/4								
							19-00		α		16/J					_			
	l						20:00		d	100%	18/mt								
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PATIENT UTOT AWARE AND ALL THE LIMBS: - OB 14-00

	SHIFT	DAY	EVENING	NIGHT
	TIME	18:45	16-00	20!00
	EYES	СР	Н	4
NEURO	VERBAL	up l	Š	5
¥	MOTOR	LP	4	6
	ARMS R/L	LP	ST	3/18
	LEGS R/L	LP	35	sh
PUPILS	R.SIZE/REACTIION	ပု	3/32	3 8
PUF	L.SIZE/REACTION	LP	2 BR	Blac
4R	HEART SOUNDS	S182	3122	Sica
CUL	VALVE CLICK	-	1 -	
CARDIO-VASCULAR	CAPILLARY REFILL	BR	BR	Br
RDIC	EDEMA	o	Ô	.0
ర	NECK VEINS	И	N	N
IARY	WORK OF BREATHING	774	पान	TA
PULMONARY	SUCTION			-
PUI	SECREATIONS	HMd	1	-
 	BOWEL SOUNDS	+	+	4
STIN	ABDOMINAL TONE	Soft	207T	Soft
INTE	N/G POSITION	11UITO	•	-
GASTRO INTESTINAL	GASTRIC RESIDUAL		_	-
GAS	LIVER	N	N	6

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	SHIFT	Di	AY	EVE	NING	NIC	3HT
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	POSITION CHANGE		Q2H		0 21+	Q241	
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		•	野宝		ARP.	ONP.	
	S/N NAME	(Damet		Sm	Sogn	2
	TIME		12.45		16-00	20:00	
	SIGNATURE		Janut_		sh.		

Mr.KALIYAN S

Sheet No.

(3)

В

71/Malc/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj

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[A	ge	:	Sex
'				
Height		Weight		BSA
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MHI/ICU/2022/076,



				ВІОСНЕ	MISTRY			_		VITA	L PARAI	METER	S			CARDIA	AC ASSIST	DEVICE		ĺ
DATE	TIME	Нb	Na	к	Ca SUGAR	BLOOD	TIME	ETCO,	BREATH SOUNDS	Sao,	RR/MT	N.BP	TEMP°F	Abd ^{on} G	TIME	IABP			R SETTING	
					SUGAR	52005	111112		SOUNDS	0002	14101011	11,51	1=			RATIO	DURATION	RATE	MODE	1
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29/12	Ս են 14	14.3	132	4.53	1.05		DP100	_	cl	981.	aolmt		,							CKITICAL CARE LEOWCHART
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	SHIFT	DAY	EVENING	NIGHT	
	TIME			00:00 04/5	
	EYES			4 4	
NEURO	VERBAL			5 5	
NE	MOTOR			6	
	ARMS R/L			She str	
	LEGS R/L			8 to 8 tr	
PUPILS	R.SIZE/REACTIION			3/2 3/2	
PU	L.SIZE/REACTION			3/8-3/8	
J.R	HEART SOUNDS			& (SL S182	
CUL	VALVE CLICK			1	
CARDIO-VASCULAR	CAPILLARY REFILL			Br Br	
RDIC	EDEMA			0 0	
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ARY	WORK OF BREATHING			TA TA	
PULMONARY	SUCTION				
PUI	SECREATIONS				
 	BOWEL SOUNDS			4 +	
STIN,	ABDOMINAL TONE			Coff Soft	
INTE	N/G POSITION				
GASTRO INTESTINAL	GASTRIC RESIDUAL				
GAS	LIVER			NN	

	SHIFT	D	AY	EVE	NING	NIC	ЭНТ
	DESCRIP.OF URINE	-				cl	ا
G.U.	PD - FUNCTION					-	-
	DRAINAGE					•	1
	PD - SITE					_	-
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SKN	DRESSING					OT	TO
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	DRESSING CONDITION					et	ما
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MIS	ACTIVITY			ļ		pe	PS
						CAB	CYP.
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	TIME					00:00	04,00
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Medway Hospitals [®]
The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)



MHI/ICU/2022/076



Sheet No.	71/Male/MHI202381394 27/12/2023/IPH2023002614			
É	_ Dr.Anbarasu mohanraj]	Age	Sex
, B	Blood Group	Height	Weight	BSA
<u> </u>	D Positive	1)boum	1 13KM	1.68m2

			BIOCH	EMISTRY				VITAL PARAMETERS								AC ASSIST			
TIME	Нb	Na	К	Ca	BLOOD	TIME	ETCO,	BREATH	Sao,	RR/MT	N,BP	TEMP°F	Abd ^{c™} G	TIME	IABP		1	R SETTING	
				SUGAR				SOUNDS		-	<u>'</u>				RATIO	DURATION	RATE	MODE	
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	TIME	TIME Hb	TIME Hb Na	TIME Hb Na K	TIME Hb Na K Ca SUGAR	Hb Na K SUGAR BLOOD	Hb Na K SUGAR BLOOD TIME 8:00 1:00 1:00 1:00 1:00 1:00 1:00 1:00	Hb Na K SUGAR BLOOD TIME ETCO2	Hb Na K SUGAR BLOOD TIME ETCO2 SOUNDS	Hb Na K SUGAR BLOOD TIME ETCO2 SOUNDS Sao2	Hb Na K SUGAR BLOOD TIME ETCO. SOUNDS Sao. RRMT	Hb Na K SUGAR BLOOD TIME ETCO, SOUNDS Sao, RRMT N,BP	Hb Na K SUGAR BLOOD TIME ETCO, SOUNDS Sao, RR/MT N,BP TEMP°F	Hb Na K SUGAR BLOOD TIME ETCO_2 SOUNDS Sao_2 RRMT N,BP TEMP°F Abd°G	Hb Na K SUGAR BLOOD TIME ETCO_2 SOUNDS Sao_2 RRMT N,BP TEMP°F Abd°°G TIME	Hb Na K SUGAR BLOOD TIME ETCO, SOUNDS Sao, RRMT N,BP TEMP°F Abd°G TIME RATIO	Hb Na K SUGAR BLOOD TIME ETCO_2 SOUNDS Sao_2 RR/MT N,BP TEMP*F Abd**G TIME RATIO DURATION	Hb Na K SUGAR BLOOD TIME ETCO, SCUNDS Sao, RRMT N,BP TEMP*F Abd**G TIME RATIO DURATION RATE	

	SHIFT	DAY EVENING				NIGHT		
	TIME	8 _a p	13.00					
	EYES	4	4					
NEURO	VERBAL	5	5					
N	MOTOR	Ь	b					
	ARMS R/L		ST					
	LEGS R/L	ST	ST					
PUPILS	R.SIZE/REACTIION	3 <u>8</u> 2	BIBR					
- Figure 1	L.SIZE/REACTION	3/BR	3/13/2					
AR	HEART SOUNDS	3,8,	Sisi					
CARDIO-VASCULAR	VALVE CLICK	-						
-VAS	CAPILLARY REFILL	BR	BR					
RDIC	EDEMA	0_	0		_			
Ö	NECK VEINS	N	H					
IARY	WORK OF BREATHING	TA.	TA					
PULMONARY	SUCTION	<u>.</u>						
PU	SECREATIONS							
٩٢	BOWEL SOUNDS	4	4-					
STIN	ABDOMINAL TONE	Sgt	391					
INTE	N/G POSITION	<u></u>						
GASTRO INTESTINAL	GASTRIC RESIDUAL	-	7					
GA(LIVER	2						

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	SHIFT	D.	AY	EVENIN	G	NIGHT
	DESCRIP.OF URINE	Ц	u			
G.U.	PD - FUNCTION	-	<u> </u>			
	DRAINAGE		-			
	PD - SITE	-				
	COLOUR	_				
	Sx WOUND-CHEST	U	u			
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	S/N NAME	Danit	Dant	-		
	TIME	8.00	12.00			
	SIGNATURE	Jan	Paret			







Mr. KALIYAN S 71/Malc/MHI202381394 27/12/2023/IPH2023002614					MHI/ICU/2022/076
Nam UHID No.		Age		Sex	Sheet No.
Blood Group O POSITIVE	Height	Ι.	Veight 53kg∆	BSA l·bsm²	С

		UR	INE		Cł	(EST DI	RAINAC	ÈΕ		GAS	TRIC	LAB S	AMPLE		Volu	715	INF	USIONS			
DATE	TIME	AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT	Amt	TOTAL	35172 1712				
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	15-00	100	250			30		30	60				5-0	312	200	400	14.0				
	16.00	45	305	-		40	<u> </u>	40	100				5-0	A30	100	500	4.0	H-ACIEN 40 (46			
	12.00	45	400			30		30	130				5-0	<u> ১</u> 3c	LAR LOO	THYTE WO	3.0	2.0			
	18-00	60	460			40		40	170				h-0	635	100	700	2.0	2.0	å		
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	22,00	80	790			lo		to	230				5-0	loas-	KABU	472 1100	4.0		.0		

SPECIFIC	OBSERVA	TIONS/PRO	DBLEMS

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DATE	TIME

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	GENITOURINARY (GU)			SKIN			
	PD			COLOUR	SURGICAL (SX) WOUND			
URINE	FUNCTION	DI	RAINAGE	Pk-Pink F-Flushed P-Pale	C-Clean Oz-Oozing G-Gaping	B-Betadine Al-Antibiotic Irrigation		
CL-Clear T-Turbid	Dr-Draining B-Blocked		L-Clear S-Blood	Cy-Cyanotic M-Mottled	Op-Open I-Infected	iitigation		
Stained HC-High Coloured	SITE			D-Dusky J-Jaundice				
BS-Blood Stained HA-Haematuria	C-Clean R-Redness BD-Block disco	oloration		SITE	PRESSURE SORE	DRESSING / Rx		
	MISCELLANEOU	s		S-Sacrum Sc-Scapular	R-Redness BD-Black discoloration	IR-Infra Red DU-Dueodem E-Eptoin dressing B-Betadine dressing EU-Eusol sitz bath ST-Sofra Tulle		
OISITION CHANGE	CHE	ST PHYSIO	ı	Oc-Occiput	SP-Skin Peeling			
Su-Supine RL-Right lateral LL-Left Lateral	CP-(DC-l	brator Chest percus Deep breath			D-Deep			
ACTIVITY	,	ebulizer		CONDITION				
PE-Passive exercise Am-Ambulated	PAR	ANSDUCER 2 AMETER 2-Arterial BP	ZERO	H-Healing SCo-Status quo S-Sloughing				
	RAP	-Right Arteria	al Pressure Arterial Pressure	LINES / TUBES	CONDITION			
		-Left Arterial		O-No redness, sw R-Redness at site Sw-Swelling at si Dr-Draining D/c-Discontinued P-Positional HL-Heparin Lock B-Blocked	te			







Mr.KALIYAN S 71/Malc/MHI202381394			М	HI/ICU/2022/076
27/12/2023/IPH2023002614 Dr.ANBARASU MOHANRAJ		Age	Sex	Sheet No.
Blood Group O POSITIVE	Height Ibaum	Weight	BSA libsm2	С

		UR	INE		CH	IEST DI	RAINAG	E		GAS	TRIC	LAB S	AMPLE		100	2m c	25ml INF	USIONS	
DATE	TIME	АМТ	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT			FENTE	発	
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SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME
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GENITOURINARY (GU)

G	ENITOURINARY (G	u)		ORIN			
	PD		COLOUR Pk-Pink	SURGICAL (SX) WOUND C-Clean	DRESSING B-Betadine		
URINE	FUNCTION	DRAINAGE	F-Flushed P-Pale	Oz-Oozing G-Gaping	Al-Antibiotic Irrigation		
CL-Clear T-Turbid	Dr-Draining B-Blocked	CL-Clear BS-Blood	Cy-Cyanotic M-Mottled	Op-Open I-Infected	ingalon		
Stained HC-High Coloured	SITE		D-Dusky J-Jaundice				
BS-Blood Stained HA-Haematuria	C-Clean R-Redness			PRESSURE SORE			
na-naematuna	BD-Block discolo	ration	SITE	AREA	DRESSING / Rx		
	MISCELLANEOUS		S-Sacrum Sc-Scapular Oc-Occiput	R-Redness BD-Black discoloration BL-Blister	IR-Infra Red DU-Dueodem E-Eptoin dressing B-Betadine dressing		
OISITION CHANGE		T PHYSIO	Oc-Occipat	SP-Skin Peeling			
Su-Supine RL-Right lateral LL-Left Lateral		nest percussion eep breath & cough	COMPITION	D-Deep	EU-Eusol sitz bath ST-Sofra Tulle		
ACTIVITY			CONDITION				
PE-Passive exercise Am-Ambulated	PARA	SDUCER ZERO METER Arterial BP	H-Healing SCo-Status quo S-Sloughing				
	RAP-F PAP-F	Right Arterial Pressure Pulmonary Arterial Pressure	LINES / TUBES	CONDITION			
	LAP-L	eft Arterial Pressure	O-No redness, so R-Redness at sit Sw-Swelling at so Dr-Draining D/c-Discontinued P-Positional HL-Heparin Lock B-Blocked	ite d			

SKIN

(1)
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Mr.KALIYAN S 71/Malc/MHI202381394					М	HI/ICU/2022/076
27/12/2023/1PH2023002614 Dr.ANBARASU MOHANRAJ		Αç	je	Sex		Sheet No.
Blood Group D POSITIVE	Height		Weight	BSA		C

		UR	INE		Cł	IEST D	RAINAG	E		GAS	TRIC	LAB S	AMPLE		Vou	me	INFUSIONS	
DATE	TIME	AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR,T	G.T.	AMT.	TOTAL	AMT.	TOTAL	OUTPUT	Prest	TOTAL		
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	17.00	100	UBE						عبا					1445		500		

SPECIFIC OBSE	RVATIONS/PROBLE	MS	1100 0 00 1	010 100 10 10 0001	DAVIDINA PER AMBADANI
DATE	TIME	415	MEDINGINAL	HND TEEL BLEAKER BREIN	REMOVED [BR. AMBARAN
	·	9.45	LEFT RADIAL	ARTERIAL LINE REHOVED	[DR. PRAVEEN JEYA KUMAR]

GENITOURINARY (GU)

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

71/Malc/MHI202381394

27/12	/2023	/IPH2023002614

Name	Dr.A	2/2023/IPH202300 NBARASU MOHAN	RAJ	, <u>'</u>		S	heet No.
UHID No.	11(1111)	<u> 1</u> 1	1 	_] [Sex	,	
Blood Group		O Posmur	Height	Weight	BSA 1.68m²		D

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MHI/ICU/2022/076



FLUID ASSESSMENT (contd.)

HAEMODYNAMICS

Blood	Group:
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		INFUSIONS (d	contd.)			ORAL	TOTAL	TOTAL	LID/	D/CEININ					LAP/	DEDI	PP	00		0,40	
DATE	TIME		MISC	TOTAL	AMT.	TOTAL	INTAKE	BALANCE	HR/mt	KYIHYM L	ST	ABP	MAP	RAP	RAP	PERI	R/L	CO	Cl	SVR	
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	22:00		≈.0	20	100	230	1385	360	প0	Bru	l	60	98	9		œ	4-4				

STAT DRUGS TIME

TOTAL INTAKE:

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TOTAL OUTPUT:

TOTAL BALANCE:

	DAY	EVENING	NIGHT
PATIENT CARE			
BATH		_	
ORAL CARE			
EYE CARE			
BACK CARE			
DRESSING/EQUIPMENT			
CHANGED			
WOUND			
CEN.LINE			
I.V.SET			
TUBINGS			
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HRT.RATE	1	bolmt	
B.P.		137157 Mm.	

DATE	TIME	REMARKS / PLAN

	_						
INFUSION PU	MPS				_		
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
8,5mm ST TVBE	FIXED Stan	88/12/23	۱ ۱			P	
MIN TUBE	PIT Nos	28/12/23	1	_		P	
IT HAF	时上	<u> </u>	١			P	
ART UNE	14D	28/12/23	1			P	
PERIPHENAL	MET	84/423	}			P	
MEDIA	_	28/12/23	,			P	
PIEURAL	UT	28/12/23	,			P	
U-CATH_		28/12/23	1			P	
V- WBING	ļ	241423	1	- 		P	
S-TUBINU	ļ	24/12/23	1		<u> </u>	P	
MIX3 NE	ļ	24/1423.	}			P	
TR-DOME		28/12/23	١			P	
THAQUET	ļ	તેમાય્ય.	1			P	
ON -TUBE	1	28/12/1	,		-	P	
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Mr.KALIYAN S 71/Malc/MHI202381					, _		
27/12/2023/IPH2023						Sh	neet No.
Dr.ANBARASU MOH	MINIMAN NAMA						~~~
			Age	.	Sex		(2))
Blood Group	-	Height	W	eight	BSA		ח
	O PUSMIVE	16200	<u>1 b</u>	3 29 1	1.6842		<u> </u>
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MHI/ICU/2022/076



FLUID ASSESSMENT (contd.)

HAEMODYNAMICS

Blood Group:

TIME	INFUSION	IS (contd.))		N/G/	ORAL														
				TOTAL		T	TOTAL	TOTAL BALANCE	HR/mt	RYTHYM	ST	ABP	MAP	RAP	LAP/ RAP	PERI	PP R/L	со	CI	SVR
			<u> </u>		AM I.	TOTAL.	II II II I								IVAF		IVL			
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STAT	DRUGS
Т	IME

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SNJ. CASIX POING IN STAT (Blo DR. PRAGENDRAINAGE:

URINE:

TOTAL INTAKE:

PREVIOUS DAY HRS

TOTAL OUTPUT:

TOTAL BALANCE:

	DAY	EVENING	NIGHT
PATIENT CARE			
BATH		1	
ORAL CARE			
EYE CARE			V
BACK CARE			
DRESSING/EQUIPMENT			
CHANGED			
WOUND			>
CEN.LINE			
I.V.SET			
TUBINGS			
HUMIDIFIER H2O			
ELECTRODES			
ALARMS VERIFIED			
VENT - HUMIDIFIER			8
-SETTINGS			<u>, </u>
HRT.RATE			go nti
B.P.			160 78 met

DATE	TIME	REMARKS / PLAN

INFUSION PU	MPS						
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
27V LINE	IN SIV	28/12/18	1				P
POT LINE	eFD	20/12/2	1				P
PERIPHERAL	RI MET	20 12 43					P
media	,)			ļ	ļ 	
PLEURAL	17	2012/28	}		ļ	ļ	P
V-chapt		20/12/2			ļ	<u> </u>	.P
DV EXTN		28/12/22	i				P
TR-DOME		2012/33	1				P
O2-TUBE		28/12/2		'			P
8- TUBE		28 12 3	1				R
			1				
				I			
		_					

71/Male/MHI202381394

Nami	27/12/2023/IPH2023002614
	Dr.ANBARASU MOHANRA I

Sheet No. Age Sex Height Blood Group Weight BSA

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MHI/ICU/2022/076



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	F	LUID ASSI	ESSMENT (co	ontd.) _c	જામાર્જ	لير اطو	W	HAEI	MODYNA	MICS	1				٠	Blo	od Gro	oup:	0	ĻV€		_
DATE	7345	INF	USIONS (cont			N/G	/ORAL	TOTAL	TOTAL	UD/mt	DVTUVM	ST	ADD	MAP	RAP	LAP/	PERI	PP	СО	CI	SVR	
DATE	TIME		_	muse	TOTAL	AMT.	TOTAL	INTAKE	TOTAL BALANCE		. KITILIN		ABP			RAP	PERI	R/L			341	
ञ्जामार	8,00			ا مره	ನಿರ	70	₹0	72	_ 1용.	74	Sin	_اسن	1331 148	₽ч	ч		Wann	14				_ ا
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	4.00					160	640	776	569	81	SINUS	0.00					Om	14				FLOWCHAKI
	15.00						540	876	369	1	BINUS	1	1			(1317P	りょ]=
	16.00						F70	1076	269	946	SINU3.	6.10				(DATM	44				
	17.00					50	620	1126	319	90	31 NUS	bill					easu	ተ ተ			_	

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STAT	DRUGS
Т	IME

PREVIOUS DAY19 HRS

DRAINAGE: 360 ML TOTAL INTAKE: 2530 ML

URINE: 1930 ML TOTAL OUTPUT: 2302 ML

TOTAL BALANCE: + 188 m L

· · · · · · · · · · · · · · · · · · ·	DAY	EVENING	NIGHT
PATIENT CARE			
BATH			•
ORAL CARE			
EYE CARE			
BACK CARE		•	
DRESSING/EQUIPMENT			
CHANGED			
WOUND			
CEN.LINE			
I.V.SET			•
TUBINGS			_
HUMIDIFIER H2O			
ELECTRODES			
ALARMS VERIFIED			
VENT - HUMIDIFIER			
-SETTINGS			
HRT.RATE	Flymt		
B.P.	Hibl but 301]	

Į 1

DATE	TIME	REMARKS / PLAN
		-

INFUSION PU	MPS						
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
DJV LINE	Pav	28/12/2	2		P		
APT LINE	ROD		2		Ple		
PER LPHERA	MET	28/12/2	2		P		
MEDIA		2	2		Ple		
DIFURAL	17	ી જેશિયાં રે.	2		PI		
U- CATH			2		P		
W 5x7 W			2		P		4
TR Dom &			2		P		
O2 TUBIN			고		P		
SOC TOBIN			2		P		ı
		1					

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71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ

ERMEDIATE CARE FLOWCHART

A

NAME WANTED THE RESERVE OF THE PROPERTY OF THE

UHID NO:

AGE:

SEX:

SURGICAL PROCEDURE: OPCABX 3GRAFT >

POSTOP DAY: 1 POD

FLUID REQUIREMENT: 34 litery

DO3 08/12/03

DATE	UR	INE	CH	EST [PRAIN	AGE	TOTAL		I.V. FLUIDS			ORAL/ R.T.		TOTAL	TOTAL
& TIME	H.T.	G.T.		AIR LEAK	H.T.	G.T.	OUTPUT				H.T.	H.T.	G.T.	INTEKE	TOTAL BALANCE
उठाप्ट्रीय १-००												50	50	50	+50
	300	300					300					&F0	300	300	
70.00		300					300					50	360	350	450
	300	600					boo								_
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opre:	EIO OT	DOED!!	TIONS		We.			, seen	CATION	LIBRUS					
SPECI	ric OE	BSERVA	HUNS/	KEMAR				MEDI	CATION		3 0				
	•								-	- -					

В





UHID NO:

RMEDIATE CARE FLOWCHART



Mr.KALIYAN S

71/Malc/MHJ202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj NAME:

AGE:

SEX:

BLOOD GROUP: 0^{+16}

HEIGHT:

162CM

WEIGHT: 63 Kg

B.S.A:

1:68m²

		НА	EMOD	YNAM	IICS			RESP	P. PARAMET	ERS	INVESTIGATIONS /	
TEMP		RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA	
97.26	8A	sun,	0.03	136	8F	Mahu	44	023/14	ps. Icl	92 ⁷ /.	ON room as r.	
	ab	SINUS	1.10	150	102	warm	44	mut	c_	917.		
	81	dimis	608	126 6A	86	Coxim	tt	26/put	cl	89%		
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			-						-			
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		<u></u>	L <u>. </u>	<u> </u>]		L					

PREVIOUS DAY - HOURS 24 HRS

tomu DRAINAGE

TOTALINTAKE 2551ML

2445 mg URINE

TOTAL OUTPUT 2455001

BALANCE + 96 ml







POSTOP DAY: | POD

71/Malc/MHI202381394 27/12/2023/IPH2023002614

Dr.ANBARASU MOHANRAJ NAME:

:RMEDIATE CARE FLOWCHART

UHID NO:

AGE:

SEX:

SURGICAL PROCEDURE: OPCAB X 3 GRAFTS

FLUID REQUIREMENT : O'A (F | day

												ODAL/S =				
DATE &	ATE URINE		CH	IEST D	RAIN	AGE	TOTAL		1.V. F	LUIDS	ORAL/ R.T.			TOTAL	TOTAL	
TIME	н.т.	G.T.		AIR LEAK	H.T.	G.T.	OUTPUT				H.T.	H.T.	G.T.	INTEKE	BALANCE	
18.00	150	1158F			-	10	1595				500	100	1 20	1226	369	
14.00	97	1686				10	1695				50°	50	4.40	1276	A19	
X0-00		1785				(0	1795	-			<i>50</i> 0	45	845	1351	444	
21-00	75	1860				Lb	1870				800	150	995	1201	369	
વ્યેન્ <u>ને છ0</u>	80	<u>(440</u>				10	1950				100		995	1501	449	
)3-00	_	Doyo				01	2050	Ы	मुक्ष	ITE	500	COD	1095	1601	449	
30[12]19 <u>00-00</u>	l	2115	-			01	2/25	Lot	<u> </u>	100	600		1095	1701	424	
01-00	loo	2215	-			10	2225	(100		റിഉമ	700	loo	1195	1901	324	
00-00	75	2290				(0_	2300	001		300	800		1195	2001	299	
03-00	80	2370				10	2380	[00]		400	900		1195	2101	279	
σ4.00	75	2445				10	2455	100		200	Loco		1195	2201	254.	
95-00	(b)	<u> १</u> ५५ (-			10	2455				lado	(101)	1298	-2301		
06 po		<u> </u>	-		-	01	2455				looc	150	14105	245)	4	
01·10		એપપડ				10	2475				loco	100	1545	255]	496	
SPEC	IFIC OI	BSERVA	TIONS/I	REMAR	KS			MEDI	CATION	I / DRUG	SS .					
6	@4-30. Folloy's catheter															

Removed . .







71/Male/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj

NAME:

RMEDIATE CARE FLOWCHART

UHID NO:

AGE:

SEX:

BLOOD GROUP:

HEIGHT:

16 x cm

WEIGHT: 63/7

B.S.A: 1.68m2

-		HA	EMOE	YNAN	lics	•	_	RES	P. PARAMET	INVESTIGATIONS /		
TEMP	H.R.	RHY.	ST.	В.Р.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA	
	a١	SUNUS	6.00	110	(4)	warm	44	29/41	E BL/cl	907.	ON room our.	
	દુર્જ	SINOS	5.00	110	80	COATM	44	31/214	BL	917.	C	
	80	any		<u> [8</u> 3	Tel	100m	नी	solt	BLa	92)		
1	82	Sing	8-0]	126 Fg	81	Warr	+	28/1	BLICC	92%		
_	80	Shy	Ø-Ð]	112/57	75		++	24 व	CL	93%		
	Ŧe	Smy	D .00	110	79	wom	4+	22/Lt	CL	90%		
	46	sinu	0-01	200	18	ocan.	[4	roht	CC	93%		
	74.	Simb	ව . උත	110	\$9	yogm.	11	l& t	CL	94%		
	80	un12	0-0	अंग्रे	83	<u>1000m</u>	4-1-	20/t	CL	95%		
	82	Sipul	0-0	68	Fq	coan	+-	22 Lt	CL	96%		
	। 8	siny	උ වර	11/2	&1	wan	- #	മ്പിപ്പ	- CL	97/		
	80	Siny	0-01	2 57	91	40019h	++	%)u±	CL	93%		
93.47	&2	&inW	001	1961	71	lean	· # _	20 t	CL	947		
	80	Sinuy	8-01	121	79	uoom	4	અૃતિ	CC	43%	: '	

PREVIOUS DAY - HOURS

DRAINAGE URINE

MEDWAY HOSPITALS

. KODAMBAKKAM (HEART)

, 1st Main Road, United India Colony , Kodambakkam, Chennai, Tamilnadu, In

044-2473 4455

care@medwayhospitals.com

Registration No

: MHI202381394

Patient Name

: KALIYAN S

Age

: 71

Gender

: Male

IP Number

: MMH/HM/IPH2023002614

Discharge Date

: 02/01/2024 4:33:00PM

Bill No

: MMH/HM/IPH202400004

Bill Date

: 02/01/2024 4:31:05PM

Ward Name

TWIN SHARING

Bed Name

: 104-A

NO DUE





