

MRD CHECKLIST

PARTICULARS	YES	NO
- IP Number allocated to each Patient		
- Name, Age & Sex of Patient		
- General Admission Consent		
- Initial Assessment of Patient / Diagnosis		
- Nutritional Assessment by Consultant		
- Plan of care counter signed by the Consultant		
- Treatment Orders - Date, Time, Name & Sign.		_ .
- Medication Order / Drug Chart - Date, Time, Name & Sign.	/	·
- Vital Signs Chart (TPR Chart)		
- Intake Output Chart	/	
- Drug Chart (Duly filled)		
- Anesthesia Consent - (8 thing) - Date, Time, Name & Sign. of both Patient & A	Anesthetist	
- Anesthesia Assessment Sheet		
- Surgery Consent - (8 things) - Date, Time, Name & Sign of both Patient & Sur	rgeon	
- Surgery Notes - Post Operative Plan		
- Pain Scoring System		
- Blood Transfusion if done		
- High Risk Procedures		1
- A copy of the Discharge Summary	/	



R Medway Hospitals

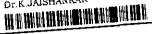
The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)

MI.BALASUBRAMANI 62/Male/MH1202381326

16/12/2023/IPH202302518

Dr.K.JAISHANKAR





ADMISSION SLIP

Admitting Doctor: 201- Jak	January .	Speciality: Con dio.	Poort				
Advised Date & Time: 11:02 Am 16/19/43							
Advised Date & Time: 11:03 AM 16/12/d3 Provisional Diagnosis:							
CAD . A	CS TVD						
CALL I	CS, TVD, PTCA						
S(P	PTCA						
Reason for Admission: Med	lical Management	Surgical Management		-			
☐ Oth	ers (please specify details	CAG					
dmission Type: Day	Care ER	Ward		•			
☐ ICU		(Specify details)					
Surgery / Procedure Name (if plann	ed):						
	CAG						
Blood Product Requirement:		details of components required in	space below)				
			-,,				
Expected Duration of Stay:	Day Care.						
Expected Cost of Treatment (as per	Financial Counseling Form	n):	<u> </u>				
		,					
Payer: Self Insurance Oth	ers:	· · · · · · · · · · · · · · · · · · ·					
Instructions to Nurse (if any):							
robl	Admit ?	n RL A					
S.C.	7 00						
Any other Instructions (if any):							
	•	_					
D6.14-7-0:		Ta N-	Τ	<u>-</u>			
Doctor's Signature Name	. Jaishankar.	Reg. No.	Date	Time			
91810 WY		49448	16/12/23	H 103			

For admission desk staff o	nly:	· · · · · · · · · · · · · · · · · · ·	
	General Ward Single Room Twin Sharing Deluxe Room Suite Room		
Admission intimation	Receipt Details	Admission 1	Fime in HIS
Date	Time	Date	Time
16/12/23	11.22am	16.12.23	11.3/Am
To be filled only if Blood	OPD ER Direct requirement specified by the		No
Front office Staff Signature	Name	Emp. No.	Date Time
Your	Francon Kumar		16-12-23 11-314



Medway Hospitals

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



Mr.BALASUBRAMANI

62/Male/MHI202381326 16/12/2023/IPH202302518

Dr.K.JAISHANKAR





MHI/HOSP/2022/129

ADMISSION FORM

Marital Status	Full Address No-186 2nd 5 proof P.P. Canadan	Telephone Number
M	Full Address No-186, 2nd Street, P.P. Canden Amnijikawai, Chennai-29	994147665
Occupation Ωt		9840198924
Referred from	Date of Time of Admission Date & Time of Discharge Tot	al No. of Days
DR Jai	Showton 16.12.23/11.31Am 16/12/08 @ 14:23 Tho	we 54 minits
UNIT	MLC Yes No If Yes AR No.:	
	FINAL DIAGNOSIS	ICD Code
<u> (10) </u>	ACE - UNETABLE ANCHINA	T25.1
CA COL	Roloelia - TRIPLE VERGEL DISEARE	924.9
	DTCA + STENT TO DISTAL & PROXIMAN	•
	0.08-19, VENICHATESWARD HOSPITAL	<u> </u>
777	POSITIVE - 19/08/2019	
TYPE	I DIOBETES NOFILITUS	E11.9
S48-7	ENDIC HYPERTENSION OPERATION / PROCEDURES	I lo
DATE	OPERATION / PROCEDURES	ICPM Code
10/03	CORONARY ANCHOCHRAM.	88.50
DATE	TYPE OF ANESTHESIA	
16/10/03	GENERAL SPINAL LOCAL REGIONAL	☐ EPIDURAL
	DISCHARGE STATUS	
☐ Cured	☐ Discharge at Request ☐ 8	Expired < 48 hours
☐ Improved	☐ Against Medical Advice	Expired > 48 hours
☐ Unchanged	☐ Absconded	Post-Operative Death
Signature of t	he consultant 10 Signature of Med	Joy 2538 dical Records Officer

AUTHORISATION FOR TREATMENT I PAYMENT

AUTTORISAT	ION FOR TREATIVE	INTIPATIVICINI
administer such drugs as may be necessary	and to perform such operation diagnosis and treatment of m	cal, Staf fof the Hospital Investigate treat and in under anaesthesia or other wise as may be y illness / patient\)
I hereby under take to settle all the bills for he basis. In any case, I shall pay all the dues be	•	to me/the patient named overleaf on a periodic the hospital.
		pove, I hereby authorise the hospital to transfer med fit and proper by the hospital authorities.
I also acknowledge having been informed if t and valuables belonging to the patient or the next of kin and I absolve the hospital of any re	is attendants have been remo	•
I have read out and explained the contents of	f the above to the Signatory in	n his vernacular .
சிகீச்சை, பணம் செலுத்துதல் முதலியவை செய்ய	ப அதிகாரம் வழங்குதல்	
	க்கு தேவைப்பட்ட சோதனை கேச்சை செய்யவும் அதிகாரம் வு	கள் எனக்கு / நோயாளி எகளை செய்து மருந்துகளை கொடுக்கவும். மயக்க ஓங்குகிறேன். நான் / இதீல் குறித்துள்ள நோயாளின்
		ட்டத் தவறினால் என்னை நோயாளியை வே றொரு ச எனது உறவினர்கள் மூலமாக பெற நான் அதிகாரம்
மருத்துவமனையின் பொது சட்ட தீட்டங்கள் பற்றி	த் தெரிவிக்கிப்பட்டிருக்கிறேன்.	
•		ந் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்லு நாயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை
மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்ப	ட்ட பிறகுதான் கையொப்பமிட்டே	∟siπ.
		B. Paj r
െയിരിഡ് അടപ്പെന്ന് വധ	தேதி	எனது/உறவினர்/காப்பாளர் கையொப்பம்
Signature of Admitting Nurse	Date: 16:12:23	Signature of the Patient / Relative / Gurdian

உறவுமுறை

Nature of Relationship Daughter





Mr.BALASUBRAMANI
62/Malc/MHi202381326
16/12/2023/IPH202302518
Dr.K.JAISHANKAR



GENERAL CONSENT FOR ADMISSION

٠, .	MR. Rula Rub Yamani. the Patient or Representative of patient have
	lease tick the correct option above and below)
	Read
L	Been explained this consent form in English, which I fully understand.
•	I give my full consent and authorization for admission and treatment at this hospital. The proposed treatment plan has been explained to me.
•	I consent and authorize the hospital, treating doctors, nursing, technical and paramedical staff to provide relevant care and to conduct diagnostic as deemed necessary by the treating doctor / team.
	·
•	I also consent to use of assistants such as resident doctors, other doctors, nurses, and other healthcare workers by the hospital and treating doctor / team.
•	I consent for clinical consultation, admission, disclosure of information required for clinical management (under confidence), routine medical examination (physical examination, palpation, percussion, auscultation), routine lab and imaging investigations, general nursing care, diet and physiotherapy assessment and counselling.
•	I have been explained about the proposed care plan, expected result(s), possible outcome(s) and expected cost of treatment/ hospital stay.

- I understand that the hospital will take due care of me / my patient but, that there is always a possibility of an unexpected complication(s) which may necessitate longer stay and / or use of intensive care services. In such cases, procedure different from those contemplated and other intervention(s) may sometimes be needed.
- I declare that, I have and will inform the doctor of my medical history including previous illnesses, allergies, drug
 reaction(s), surgical procedure, relevant medical family history and all other facts relevant to my treatment. I
 shall not hold the hospital/ doctor responsible for any consequences which may arise due to non-disclosure of
 relevant information on my part.
- I declare that I have been explained about my rights and responsibilities.
- I have been made aware of the rules and regulations of the hospital including those related to security and I
 promise to abide by them.
- I understand that in case of some unexpected event occurring during the course of my stay I may be suggested
 a transfer to another hospital / healthcare organization, as considered appropriate by my treating doctor.
- I understand that, drugs, consumables and devices will be charged on an 'as actual' basis as per the hospital
 tariff. I have been informed and I understand that there can be usage of certain reprocessed items during the
 course of the treatment. I also understand that only full strips of medicines shall be issued and returned. I
 declare that I take full responsibility of settling the bill before leaving the hospital premises at the time of
 discharge.

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

	Signature / Thumb Impression*	Name	Date	Time
Patient	Thri	N. BALASOBRAMANI	16.12.23	11.31A
Surrogate/Guardian (if applicable #)	B. Raji	B. PAJESWARI (Write name and relationship with patient)	16 1223	11.3/4
Reason for Patient is unable to give consent be surrogate consent		pecause:		
Witness	B. Raj	B. LAJESWARI	16.12.23	11.314
Interpreter (if applicable)				

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







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DAY CARE DISCHARGE SUMMARY

T' No.

IPH202302518

D.O.A

: 16/12/2023

GIII

: MHI202381326

D.O.P

: 16/12/2023

ame

Mr. BALASUBRAMANI

Room No.

: RL

Age / Gender

62Years / MALE

Consultant

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

D.O.D

: 16/12/2023

Director and Clinical Lead

Cardiology and Electrophysiology

DIAGNOSIS:

CAD -- ACS - UNSTABLE ANGINA

CAG (10.08.19) – TRIPLE VESSEL DISEASE

S/P PTCA + STENT TO DISTAL & PROXIMAL LCX (20.08.19, VENKATAESWRA HOSPITAL)

TMT--POSITIVE-19.08.2019

TYPE II DIABETES MELLITUS

SYSTEMIC HYPERTENSION

PROCEDURE: CORONARY ANGIOGRAM DONE ON 16.12.2023 - TRIPLE VESSEL DISEASE / PATENT LCX STENTS.

BRIEF HISTORY:

Mr. Balasubramani, 62years/ male, Presented with complaints of shortness of breath on exertion. plaints of bilateral pedal edema. He came to Medway Heart Institute on 16.12.2023 and advised for Coronary ogram for which he has been admitted.

10 fever, cough, vomiting, diarrhea.

wn case of Type II diabetes mellitus, Systemic hypertension on medication.

C/O CVA, hypothyroidism and Dyslipidemia.

... EXAMINATION:

Patient Conscious, Oriented and afebrile.

PECCLE

NIL

HR

94bpm

 $|\mathcal{X}|$

153/80 mmHg

SPO-

97% in room air

(XS)

S1S2(+)

175

BAE

Abdomen $(-\sqrt{3})$

Soft

NFND

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

🕇 @MedwayHospitals

In @medway-hospitals

@medwayhospitals

94457 94457 1800 572 3003

Medway Group of Hospitals

(O) @medwayhospitals

Medway Centre of Excellence (Chennai)

Kodambakkam 044-2473 4455

Mogappair 044-26530011

Kumbakonam 044-2473 4455

Chengalpattu 044-27426829

Villupuram 04146-242000

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

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

MHI/HOSP/2022/118



UHID: MHI202381326



F.Co.: Normal sinus rhythm, HR @ 86bpm, T wave inversion in lead II & aVF

FCHO: Concentric LVH. No RWMA. Normal LV systolic function. EF – 62%. Grade I LV diastolic distriction. Trivial TR/MR. No PE / PAH.

COURSE IN THE HOSPITAL:

Fig. Balasubramani, 62 years/ male, underwent Coronary Angiogram by right radial access on 16.12.2023 which reverled TRIPLE VESSEL DISEASE / PATENT LCX STENTS. Post procedure was uneventful. He is a table clinical condition.

ADVICE MEDICATIONS:

1	NAME OF THE DRUGS WITH	DOSAGE	FREQUENCY		ROUTE	RELATION	DURATION		
()	GENERIC NAME		M	A	N	1	SHIP WITH MEAL		
 	TAB. ECOSPRIN (ASPIRIN)	75 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE	
3	TAB. CLOPILET	75 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE	
,	TAB. ATORVA (ATORVASTATIN)	20 MG	0	0	i	ORAL	AFTER FOOD	TO CONTINUE	
1	TAB. ANGIPLAT (NITROGLYCERIN)	2.5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE	
ī.	TAB. TELMA (TELMISARTAN)	40 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE	
,	TAB.NEBICARD (NEBIVOLOL)	5 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE	
	TAB. RABEKIND DSR (RABEPRAZOLE AND DOMPERIDONE)	1 TAB	1	0	0	ORAL	BEFORE FOOD	TO CONTINUE	
	TAB. GOBEN (GABAPENTIN)	300 MG	0	1	1	ORAL	AFTER FOOD	TO CONTINUE	
	TAB. NIKORAN (NICORANDIL)	5 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE	
	TAB. JANUMET	500/50 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE	
	TAB. ISONIT (ISOSORBIDE DINITRATE)	5 MG			S/L	ORAL	sos	sos	
	TAB. NEUROBION FORTE	1 TAB	0	0	1	ORAL	AFTER FOOD	TO CONTINUE	

"I understood the Content of the discharge summary."

€ @MedwayHospitals

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

@medwayhospitals medway-hospitals medwayhospitals



 Kodambakkam 044-2473 4455
 Mogappair 044-2473 4455
 Kumbakonam 044-2473 4455
 Chengalpattu 044-2472 045
 Villupuram 044-2473 044-247

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



UHID: MHI202381326



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DISCHARGE ADVICE						
DIET LOW SALT & LOW FAT & DIABETIC DIET.						
PHYSICAL ACTIVITY	AS ADVISED					
REVIEW	REVIEW WITH CTVS TEAM FOR CABG AFTER APPROVAL FROM CHENNAI PORT TRUST.					

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

(for) fromu

CONSULTANT SIGNATURE

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

ed by : Ezhilarasi.

Dr. K. JAISHANAR Reg. Not 49448

#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel: 044 - 4310 8959						94457 94457
f @MedwayHo	spitals	medwayhospitals	in @medwa	y-hospitals	@medwayhospitals	1800 572 3003
Medway Group of Hospitals					Medway Centre of Exc	ellence (Chennai)
Kodambakkam 044-2473 4455	Mogappair 044-26530011	Kumbakonam 044-2473 4455	Chengalpattu 044-27426829	Villupuram 04146-24200 0	Heart Institute 044 - 4310 8959	Institute of Pulmonology 044-2473 4454
E-mail : info@medv	wayhospitals.com	Website : www.me	dwayhospitals.com	CIN: U74900TN20	011PTC083665	MHI/H0SP/2022/118

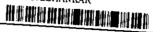


(A Unit of United Alliance Healthcare Pvt Ltd)



62/Malc/MHI202381326 16/12/2023/PH202302518

Dr.K.JAISHANKAR





DAY CARE INITIAL ASSESSMENT FORM

Dat	Date: 6 12 33 Time of arrival: 11. 36						
	A (to be filled by Nurses						
Vital Respi	Signs: Temp (°F) Printed in the contraction: (°F) Printed in the contraction (°F) Printed in the contr	ulse / HR: 9 (beats/i	min) BP: 153 80 (m 68 (cms) Weight: 18.8(ımHg) (kgs) BMI <u>2</u> 7	g kg/m²		
_	Language Barrier: ☐ Yes E	No If yes, please call Lar	nguage Coordinator / Trans	lator			
Alcol Do ye	Psychosocial Assessment: Alcohol Intake: Yes No Substance Abuse: Yes No Smoking: Yes No Do you have any special religious, spiritual or cultural needs to be considered? Yes No If Yes, specify details:						
Pain: Pain F F Du	Pain Screening Pain: Yes No. If Yes, Score: 0 0 0 Pain Scale used: PIPPS (28 weeks to < 38 weeks) CRIES (38 weeks - 2 months) FLACC Scale (2 months - 7 years) Wong-Baker FACES Pain Rating Scale (7 years - 12 years) Numerical Rating Scale (Age more than 12 years) Duration: Location: Pain Character: Dull Aching Sharp Stabbing Shooting Burning Referred / Radiant Pain						
Last 3	Nutritional Screening: Last 3 months Appetite □ Increased □ Decreased □ No Change Last 3 months Weight □ Increased □ Decreased □ No Change						
□ A	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 met initiate detailed fall assessment and fall prevention protocol						
□н	Fall Risk Screening (for pediatrics) H/O fall in last 3 months Neurological problem (vertigo, seizure, etc) Deranged Mobility No Risk In case of 2 or more criteria met initiate detailed fall assessment and fall prevention protocol						
	Signature	Name	Emp. No.	Date	Time		
Nurse	, Alm	Authi	0282	16/12/23	11.42		

Pai	Part B (to be filled by Physicians)						
Chi	Chief Complaints Hilo Shestness of boeth on exection cend process of boeth one exection the blasteral, edd edone						
	HOU	en l	Pro	4 ense	& more		
	10/ 10/	16	~2.0 x	edal or	done		
	406 6	West "	su /				
Bas	4 5 8 - 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		· -				
Pas	t Medical History				•		
	To D.	/					
Pe	rsonal History						
	mroed.					ı	
Sim	sidiaant Family History						
Sigi	nificant Family History						
Cur	rent Medication						
S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay	
1	6. Angelplet	252	PL	1257.	0 < > ×	© ✓Yes □ No	
2	1 Ontor Mus	53	No	100	2000 Jours	[☐ Yes ☐ No	
3	7. Abones	207	Plo	on	dorson of y	☐ Yes ☐ No	
À	7. Ellymor	75	Plo	010	18	☑Yes □ No	
5	1. Januar	19500	Pla	010	1,	☐ Yes ☐ No	
6	1. relizet	401	Ro	101.	ι,	□ /fes □ No	
1	7. Llotrel	My	No .	000.	,,	☑Yes ☐ No	
8	1. metaylor	20 My	Ple	107	(.	∠ Yes □ No	
9	7- Micon	32	Plo	100		☑ Yes □ No	
		1			_	☐ Yes ☐ No	

Clinical Examination / Investigation

CUS: SISADE

Esher Y. O. L. V.

76:68/0 plb:278000

K: 46.

Cred: 1.1

Provisional Diagnosis

on stable Anyma MIN

Plan of Care (including Investigations Ordered)

(Alr.

Doctor's Signature

Name Dockmath Reg. No2585) Datell/12/4 Time 1130





Mr.BALASUBRAMANI 62/Male/MHI202381326 16/12/2023/PH202302518

Dr.K.JAISHANKAR





ery heart beat counts

	DOCTOR'S PROGRESS NOTES				
DATE	NOTES				
16/12/23	CAG (CAG NO. 3412)				
1,10 BM	_pt radial aceus				
	-SF_sheath				
	- SF TIA -> CAG done				
	CMCA - (D). Bilancates into LAD 210x				
	LAD - Type 3 newel. Proximal CAD shows wild plagning.				
	Mid LAD chous diffuse estatia followed by 80% tubulen stempts Distal LAD shows 70% trubulen stempts Green & major diagonals				
A :	Distract CAD shows 10% patricks are diffusely disease				
Ð _i ·					
	LCX - Nordamant. Prox a dietal LCX charac patent etente c				
·	hund megulentres. Bure 2 mejor one. on, Arostmal punt				
	Shows 70% long sagnut desease. OM, shows lined ingulate				
	RCA Doninant- Prox. RCA shows long Segrent disease upto 70% of				
	Mid RCA show total occlusion. Dietal RRA, PDA & Au Viralud				
 -	by Grade I homo & hotencollaterale				
	1ma Lima & RIMA (D).				
	Drup: Pt dominant / TVD / Patent Los Stente.				
	Adu: CABZ × Grafts to LAD, Major on RECA				
	97211				

DATE	NOTES
23	griß: Do. h. Atechi-
	Come Daniel From Cath but.
16/12/23	
7 Pm	CAE = PTO.
,	Vi hah Stable.
	Plura - CABG.
<u></u>	91310-
mgd	pt can he down body
	91810





Mr. BALASUBRAMANI

62/Male/MHi202381326 16/12/2023/IPH202302518

Dr.K.JAISHANKAR





PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: 💯	Diagnosis: ULA COD 70000 HTM . Allergies if any: NAD.							
From (Area) To (Area) Date	Time	Reaso	n for Transfer / Na	me of Pro	cedure	
RL	RL (auxab 16/12/23/13.00 CAG							
Method of Trai	nsfer: On Bed On	Wheelchair 🗌 On S	Stretcher		<u> </u>			
	ASSESSMENT OF PATIENT: General condition of Patient: Conscious Conscious Un-conscious							
Language Bari	rier: 🗆 Yes 🖼 No ᠺ If	Yes, specify:						
Fall Risk Cate	gory: 🗌 Low Risk 🔲 Me	dium Risk 🖰 High R	isk	_				
Vital Signs (to b	e documented at the tim	e of shifting):						
Temp (°F)	RR (breaths/min)	Pulse (beats/min) :	SpO, (%)	BP (mmHg)	Pain	Score	
78.6	22 b m	97P/W		97+	153/80	011	0	
FLACC Scale Twimerical Ra Any pre-medical Any critical info	Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months) ☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years) ☐ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose) Any pre-medication given: ☐ Any critical information: ☐ Any specific recommendation:							
	Signature	Name			Emp. No.	Date	Time	
Handover by	1197	Duth	77	- ,	0282-	16/10/2	17	
After Procedure: Procedure completed: Yes Yes Any critical information: Ni Vital Signs (to be documented at the time of shifting):								
Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain	Score	
98 F	22 hr mi	at bothing	7 0	<u> 84</u>	162/80/104	10/10	7	
Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months) ☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years) ☐ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)								
	Signature	Name			Emp. No.	Date	Time	
Handover by	+	VIANGIA	any		076	16/2/23	14:15	
Handed over to	608	1 Nathi	ua		0910	16[12]23	14.15	



16/12/2023/#H202302518

Dr.K.JAISHANKAR





CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

CONDITION AND PROCEDUKE

Dr Th. Litta Kar Rhas explained that I have the following condition:

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

RISKS OF THIS PROCEDURE

The risk of coronary angiography depends on:

(i) The nature of coronary artery disease (ii) The pumping status of the heart (iii) Your age and general health These are some of the more serious risks that can happen, but are not the only risks:

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

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

On the basis of the above statements,

I REQUEST TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship	MR BALASURIAMIN	MR. BALBSUBREDMAN	16/12/23	11-38
witness	*Balan	B. RAJESUARI	1612	11-38
Doctor	0724	Dr. salar sudham	16/12/88	11.88.
Interpreter				







Medway Hospitals [®]
The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)
,
Deticat Details (Affin Label hars)

Patient Details (Affix Label In			
Name:	· '	<u>கருதய ஆன்னியோகிராம்</u> பரிசோதனைக்கான	منسنه
UHID:		<u>ுமுறுவ அன்னெய்யனாம் பாசோறியைகளையு</u>	Munn
DOB: Sex:	:		

den	where	செயல்முக	

பழைய இரும்புக் குழாய்களில் துருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாரடைப்பினை ஏற்படுத்துகிறது. கிதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான கிதயச்சுவர் சிரை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியரோகீராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு லோக்கல் அன்றதீட்டிக் (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கதீட்டர்) கவட்டை/கையிலுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிரை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டுள்ளன கான்ட்ராஸ்ட் மீடியத்தினை (எண்ஸ்ரே டை) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுபக்க இருதய கீழறை) இந்த கான்புராஸ்ட் மீடியம் உட்செறுத்தப்படலாம். இது இதயத்தீன் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்ப் செய்கிறது என்பதை மதிப்படவும் மேற்கொள்ளப்படும். இப்படங்கள் நமக்கு இதயச்சுவர்சிரை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கீறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகீட்சையை மேற்கொள்ள முடியும். இவை பை-பாள் அறுவை சிகிட்சையாகவும் இருக்கலாம் அல்லது ஆன்றுயேய்யினாஸ்டி (பனூன் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமணியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

சேலைக்குறையிறுள்ள கிடர்பாடுகள்

இதயச்சுவர் சிரை ஆன்ஜியோரோஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

 இதயச்சுவர் சிரை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஓற்பட வாய்ப்புள்ள சில தீனிற கீடர்பாடுகள் பீள்வகுமாறு. ஆனால் கேஷகள் மட்டுமே முருமையாள கீடர்பாடுகள் அல்ல

10,00 -ல் ஒருவருக்கும் கீழ் (0.0 001 சதவிக்தம்)	(a) கதிர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
1000-ச் ஒருவருக்கு (0.001 சதவிக்தம்)	 (b) வலிப்பு. இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாரடைப்பு (d) எக்ஸ்-ரே காண்ட்ராஸ்ட் மீடியத்தீன் (டை) ஆபத்தான வீளைவுகள் . இவை ஏற்பட்டால் உரங்களுக்கு ஆன்துமா. அதீர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2.50,000 முதல் 4,00,000 ஊசிகளில் ஒன்று மரணத்தையும் வீளைவீக்கலாம். (e) குத்தப்பட்ட இடத்தீல் பெரிய அறுவை சிகீச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரகால இதய அறுவை சிகீச்சை அல்லது ஆன்அயோபினாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதீர் பாதீப்பு காரணமாக அதீக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
100-ல் ஒருவகுக்கு (0.01 சதவிக்தம்)	 (I) இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகீச்சை தேவைப்படும் (j) குத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகீச்சை சரிபாடு. இதனால் மருத்துவமளையில் நீண்ட நாட்கள் தாங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) கான்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலுகுறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிக்தம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவிலான சிராய்ப்பு அல்லது வீக்கம்
பெரும்பாளை மக்களுக்கு	(n) കീறிய அளவிலான கிறாய்ப்பு

தோயானி ஒப்புதன்

செயல்முறையையும் எனக்கு விளக்கீனார். செயல்முறையிலுள்ள இடர்பாடுகள், மயக்க மருந்துகள் உட்பட எனக்கு குறிப்பாக ஏற்படும் இடர்பாடுகள் மற்றும் சிக்கல்கள் ஏற்பட்டால் என்னவாகும் எண்பவைகளை நான் புரிந்து கொண்டள்ளேன். மருத்துவர் பிற தொடர்புள்ள சிகீச்சை விருப்பத் தேர்வுகள், அதன் இடர்பாடுகள் மற்றும் சிகீச்சை மறுப்பதற்கான என்னுடைய உரிமை ஆகியவைகளையும் எனக்கு விளக்கீனார். அதன் தொற்றின்மை மற்றும் ஒருமைப்பாடு உறுதிலையப்பட்டவுடன் சில மறு செயலாக்கப்பட்ட பொருட்கள் பயன்படுத்தப்படலாம் என்று எனக்கு விளக்கப்பட்டுள்ளது. அவர் என்னுடைய முன் கணிப்புகள் மற்றும் செயல்முறையை மேற்கொள்ளாமல் இருப்பதால் ஏற்பட வாப்ப்புள்ள இடர்பாடுகள் ஆகீயவைகளையும் எனக்கு வீளக்கீனார். என்னுடைய நிலை குறித்து என்னால் கேள்வி எழுப்ப முடிந்தது மற்றும் என்னுடைய கவகைகளை தெரிவிக்கவும். செயல்முறை மற்றும் அதன் பலன்களை தெரிவிக்கவும் மற்றும் எனது சிகீச்சை விருப்பத்தேர்வுகள் குறித்த கவகைகளையும் என்னால் தெரிவிக்க முழந்தது. என்னுடைய கேள்விகளும் மற்றும் கவலைகளும் கலந்தாலோசிக்கப்பட்டது மற்றும் எனக்கு திருப்திகரமான முறையில் அவற்றிற்கு பதீலளிக்கப்பட்டது. அசாதாரணமான குழலில், எனக்கு இரத்தமேற்றுதல். ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகீச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டுள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகீச்சையளிக்கப்டும் என்பதை எனக்கு விளக்கீனார். இச்செயல்முறையீனால் என்னுடைய நீலை மேம்படும் என்பதற்கு எத்தகைய உத்தீரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டுள்ளேன்.

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்ளீறேன்

	கையெழுத்து	பெயர்	தேதி	நேரம்
நோயாளி (பாதுகாவலர்) உறவுமுறை				_
சாட்சி	11.1			
ம <u>ருத்த</u> ுவர்	* ,			
மொழிபையாப்பாளர்	·			









Every heart beat counts

(A Unit of United Alliance Healthcare Pvt Ltd)

CORONARY ANGIOGRAM REPORT

: MHI202381326 PATIENT NAME: MR. BALASUBRAMANI **UHID** IP NO : IPH202302518 AGE/GENDER : 62 YEARS / MALE

CONSULTANT D.O.A : 16.12.2023 : Dr. Jaishankar, K MD., DM., FIAMS

Director and Clinical Lead D.O.P : 16.12.2023

Cardiology and Electrophysiology

CATH DATE	16.12.2023	DONE BY	DR. JAISHANKAR
CATH NO	3412	ASSISTED BY	SN, SATHYA
CATH DURATION	5 MINS	TECHNICIAN	MR. TAMIL
HEIGHT	168CMS	PHYSICIAN ASSISTANT	MS, SHALINI
WEIGHT	78KGS		

CLINICAL DIAGNOSIS: CAD - ACS - UNSTABLE ANGINA, CAG (10.08.19) - TRIPLE VESSEL DISEASE, S P PTCA + STENT TO DISTAL & PROXIMAL LCX (20.08.19, VENKATAESWRA HOSPITAL) TMT - POSITIVE - 19.08.2019, TYPE II DIABETES MELLITUS, SYSTEMIC HYPERTENSION.

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

APPROACH : RIGHT RADIAL ARTERY

SHEATH : 5FR

CATHETER : 5FR TIG

CONTRAST MATERIAL: NON-IONIC, CONTRAPAQUE

MEDICATIONS : Inj. Heparin 2500 IU

COMMENTS:

LMCA - NORMAL. BIFURCATES INTO LAD AND LCX.

LAD - TYPE III VESSEL AND GIVES RISE TO 2 MAJOR DIAGONALS. PROXIMAL LAD SHOWS MILD PLAQUING. MID LAD SHOWS DIFFUSE ECTASIA FOLLOWED BY 80% TUBULAR STENOSIS.DISTAL LAD SHOWS 70% TUBULAR STENOSIS, MAJOR DIAGONALS ARE DIFFUSELY DISEASED.

LCX - NON-DOMINANT AND GIVES RISE TO 2 MAJOR OMs. PROXIMAL AND DISTAL LCX SHOWS PATENT STENTS WITH LUMINAL IRREGULARITIES. OMI PROXIMAL PART SHOWS 70% LONG SEGMENT DISEASE, OM 2 SHOWS LUMINAL IRREGULARITIES.

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

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Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

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Chengalpattu

Villupuram. 04146-242000

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





RCA - DOMINANT AND GIVES RISE TO PDA AND PLV BRANCHES. PROXIMAL RCA SHOWS LONG SEGMENT DISEASE UPTO 70% STENOSIS. MID RCA SHOWS TOTAL OCCLUSION. DISTAL RCA.PDA & PLV VISUALISED BY GRADE II HOMO & HETEROCOLLATERALS.

LIMA & RIMA- NORMAL

IMPRESSION:

TRIPLE VESSEL DISEASE / PATENT LCX STENTS NORMAL LV FUNCTION RIGHT DOMINANT SYSTEM

ADVICE:

CABG (GRAFTS TO LAD, MAJOR OM & RCA)

CONSULTANT SIGNATURE

- for onle

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

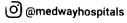
To visit at www.medwayhospitals.com

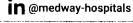
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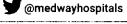
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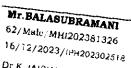




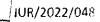


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DATE &		Observation / Action			Signature with Emp.No	
हिंगि सक्य					<u> </u>	
11-36.	Ot Recoi	vod toom k	RL, Kor	chen	\ <u>\</u> 2	
	▼	incuous &	_		TOTAL	
		are moni			~ • • • • • • • • • • • • • • • • • • •	
· · - · · - · · - · - ·	skin p	reparation	done.		<u> </u>	
13.00	pt Ship	ted to cath	lab.		Marine	
	 	Cath Cab				
16/23	· · · · · · · · · · · · · · · · · · ·	celved of ros		o Cath	= + %	
13.00	N _	us and one	rdel			
	-Juliation	Staple.	10		VIII I	
3.[0		le dlapping	ouno.	CH9	10120	
	produe	eforted.	0 / Ac			
13.20	2) Pt /	under Local anaesthesia				
12 12	N _	•	. 10	am Parha		
13.2		14 LOO MCB + S			Oleve	
13.95	>\ (hi) H	IA given old Dr. Salar suchan (si)				
	0/B Do. Calas sudhan (cir)				\mathcal{O}	
13.20	=) BP: 160/82 (112) mmHs. HP: 96 b+ ln4				Mite	
	bptg: 98-1	Vitals stabl	<u>\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ </u>		J - 019.	
13.35	2) proce	lue CAG	done. E	<u> </u>	- · · 및	
	Radial axterial shooth removed				$\sim \sim \sim$	
	Tight playter handage applied				1116	
	no oci	ng & heme	forms.		1-019	
		l	Emp Ala	Date	Time	
Document	Signature	Name	Emp . No.	Date		
endorsed by	08/_	eath iga	0016	16/12/23	3.46	
	. 30	3-117	<u></u>	<u>L.</u>	<u></u>	

DATE & TIME	:	Observation / Action	<u> </u>		Signature with Emp.No					
	gic comerts.	Shifted to Ex		///)					
	Pt Receive	gover to ERS	pt 13		1004 1004					
	monitoring a	Monitoring & Rewading. Rt Radial approach, puncture sid								
)	mere 15 n	19.	0207							
	17:23, F P+ VIIAL	riented.	0240							
i	900 - 950	Pt vitals ie HP-83/mt SPOD-952, BP-160/8pmmHg Checked & ROCOVTED								
	810 b	Pt IV 19r	Remo	red						
	& honder	pt all ngover t	o pt	6 f	0940					
	-									
Document	Signature	Name	Emp . No.	Date	Time					
endorsed by	Jayl	Joyladen	0000	16/12/0	18.00					





SAFE PROCEDURE CHECKLIST Adapted from WHO Safe Surgery Checklist



Every heart beat counts

Mr.BALAS	UBR	Αl	MA	١N
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Name of the Procedure :	CAG	Location: C9th L	ah Date & Time : ∫	62/Mulle/MHI202381326 16/12/2023/:rH202302518
Does the Procedure involve	e Procedural Sedation :	· /-		Dr.K.JAISHANKAR
SIGN IN 3. /O Before Induction of Procedural S	Sedation	TIME OUT 3 - 90 After procedural Sedation and before procedural	SIGN OUT 13 - 3 (When Doctor indicates that the Procedure is completed	
(Anaesthetist / Qualified Physicia Sedation + Nurse + Technician + Do	an administering Procedural octor performing the procedure)	(Anaesthetist or Qualified P	al Sedation + Nurse + Technician + Doctor dure	
Patient Confirmation	<u>, , , , , , , , , , , , , , , , , , , </u>	All team members introduce themselves by Name		To be done for each procedure in case of multiple procedures
Identity by two identifiers	☐ Yés	Identity by two identifiers	DY'es	Name of the Procedure done written down
Procedure	Yes	Procedures	Yes	Name and site of all specimens / investigations Yes NA confirms labeling and sent to lab
Side	ØŔt □Lt □NA	Side PA DedPal Cryfer Expected Blood loss NA	Proat DAT Lt DNA	Committee labeling and sent to lab
Consent	Yes	Position Scapine	Yes	Any recovery concerns : ☐ Yes ☐ None
Known Allergy	☐ Yes ☑ No	Consent	☐Yes ☐NA	If Yes, Pls. specify:
	If yes, plaese specify	Required equipment and implants available	DYes □NA	
Difficult airway / aspiration risk	No ☐ Yes, equipment	Essential Imaging displayed	✓Yes □NA	
/ dentures	and assistance available	Antibiotic prophylaxis within last 60 minutes	☐Yes ☐MÁ	
Possibility of hypothermia	✓ No ☐ Yes, warmer in place	Name of the Antibiotic given		Any Equipment / instrument problem that needs to be addressed:
	Y	Venous Thromboembolism Prophylaxis Provided	☐ Yes ☐ NA	addressed: Yes ☐ None ☐ Yes ☐ None
All concerned anesthesia equipment		Anticipated duration briefed	☐ Yes	
□8po2 □NIBP □Othe	rs pls. specify $\mathcal{E}^{(\ell)}$	Anticipated blood loss briefed	☐ Yes ☐ NA	[(1
Pre OP medication taken	☐Yes ☐No	Adequate fluids and blood available	☐Yes ☐ NA	
		Team briefed on any critical or unexpected steps	□ y⁄es	Corrective action;
Required equipment for	Yes NA	For procedural sedation cases Any patient specific concerns:	☐ Yes ☐ None	
procedure available		Intra procedure glycemic control	Yes PNA	4
	<u> </u>	Any concerns about sterility	Yes None	
Anaesthetist Doctor giving Procedural Sedation	Doctor performing the Procedure :	Nurse: Din Sandh	1 7 1	a This G Others Please Specify:
Date :	Date: 6 12	23 Date: (6/12/2)	Date: Ahly	Date:
Time:	Time: 13.1	Time: 13.45	Time: 13.45	Time :







Every heart beat counts

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Procedure Monitoring Sheet (Cath Lab)

		RAM	

62/Male/MHI202381326 Patient Name:

16/12/2023/JPH202302518

UHID / IP:

Dr.K.JAISHANKAR

Age / Sex: 62 y) M

Ward Unit: RL

Diagnosis: USA (CAD/TO DM/HTN Consultant: Pre Procedure Checklist (Please tick appropriately – To be filled by the Ward Nurse) **PARAMETERS** YES NO NA Vital signs: BP: 153 80Temp.98.c. Pulse9...... RR22..... SPO2:97. Urine voided **Bowel preparation** Pre-procedure medication administered Procedure site marked Skin preparation done 8.20 am NPO '_ Loose Tooth removed Contact lenses / Eye glasses removed Prosthesis present Jewellery/Nail polish removed Checked for Allergies (Drug / food) IV line/In-situ Consent taken Investigation reports / Documents received Signature of Nurse: Date & Time: 16/12/23 @ Intra - Procedural Record (To be filled by the Cath Lab Nurse) Time HR / min RR / min BP mmHq SpO₂% Medication / Remarks Sign. of Nurse 00

iime : .				13.45	Route:	RF	Redial	astoni	nl la
Compli	cation :	~	; [·	Route:		•	appro	ail
BP: BYOULI Dista l F	<u> 62 80</u> a Pulse:	[[0£) F	mmHg, HR	: <u>946+M+</u> , RR: , Puncture Site: <u>ho</u>	22 h	x/w/, sp02:		2-).
♦ WaDie♦ Infoa)b)c)♦ Reito ti	ft To: Wad rest up serve pur tch for Puty If patient If dressir If limbs a move 121	Medicoming is literat.	cal Coplair Loos	Officer SOS as of any Di se or Socke	scomfort d with Blood se ressing on 17/12/23		at <u>/ 3</u> · ©	O AM /PM	after informing
								me & Signature	of Consultant
					DOOT DROOFFILEE OF	OCDV/A	TION		
e & Time	RP.	ΗВ	BB	SpO2%	POST PROCEDURE OB			Remarks	Sign of Nurse
			RR	SpO2%	Site Evaluation	Extre	mity Status	Remarks	Sign. of Nurse
te & Time //2/23 2.\ 55				SpO2%		Extre	mity Status	Remarks	Sign. of Nurse
					Site Evaluation	Extre	mity Status	Remarks	<u> </u>
					Site Evaluation	Extre	mity Status	Remarks	<u> </u>
					Site Evaluation	Extre	mity Status	Remarks	<u> </u>
					Site Evaluation	Extre	mity Status	Remarks	<u> </u>
//2/23 L: 55	164/82	<i>a</i> 4	o'à	99-/	Site Evaluation Right Racliful artery approach	Extrei No o o	mity Status		Roody
//2/23 L: 55	164/82	<i>a</i> 4	o'à	99-/	Site Evaluation Right Racliful artery approach	Extrei No o o	mity Status		Roody
//2/23 L: 55	164/82	<i>a</i> 4	o'à	99-/	Site Evaluation Right Racliful artery approach	Extrei No o o	mity Status		Roody
//2/23 L: 55	164/82	<i>a</i> 4	o'à	99-/	Site Evaluation	Extrei No o o	mity Status		Roody

Patient shift to: ☐ Recovery Room ☐ Patient Room ☐ CCU ☐ Other_ Name & Signature of the Nurse : Date & Time: 12/23





Mr.BALASUBRAMANI

62/Male/MHI202381326 16/12/2023/IPH202302518

Dr.K.JAISHANKAR





Date: 76

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK Time:	N	Æ	
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 Desponds 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 Molat 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. Rarety Moist Skin is usually dry, linen only requires changing at routine intervals	4	4	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	1	
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position 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	3. Adequate Eats over half of most meals. Eats a total of 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	5	3	
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. Nor chair		3 19	3 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:	Z	1	_

PRADEN COALE FOR REPORTING PRECEIPE IN HERV DICK



PAIN RE-ASSESSMENT & MONITORING CHART



Mr.BALASUBRAMANI

62/Malc/MHI202381326 16/12/2023/IPH202302518

Dr.K.JAISHANKAR



MHI/NUR/2022/052



Every heart best counts

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial Senior S & Emp. No. Initial Emp. No.	&
16/10/103 11 · 36	%0	No pais		-		0292	a l
		patient	SPECEL	seo from	carrolab.		
14.5	0/10	nlo país	_	•		Day Saloo	J.
15:15	0/10	No pais	•			Days Just	ou
16:15	ળાળ	No pais	j	_		\$0.40 Jay	200
MUS	olio	No Pain				0040 Mas	1
		P-1	901	discha	rged @ 17:23		

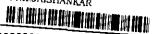




Mr.BALASUBRAMANI

62/Male/MH1202381326 16/12/2023/IPH202302518







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

		athalas						
	Date	1963,						
	Time	11-26				_		
S. No.	PARAMETERS	, -	·· <u>··</u>					
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0						
2	Bedridden recently >3 days or major surgery within four weeks	0						
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	O	· L					
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	Ø						
5	Entire leg swollen (Assess for both legs)	0					<u> </u>	
6	Localized tenderness along the deep venous system (Assess for both legs)	0						
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0						
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0		_				
9	Previously documented DVT (Assess for both legs)	0						
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0						<i>y</i>
	FINAL SCORE							
Low R	isk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	10W						
	DVT prophylaxis started	☐ Yes	☐ Yes ☐ No					
	Signature & Emp. No. of RN	NO BO						
	Signature & Emp. No. of Sr. RN	1/						

000



The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



Mr.BALASUBRAMANI

62/Male/MHI202381326 16/12/2023/IPH202302518

Dr.K.JAISHANKAR





MHI/NUR/2022/046

MODIFIED MORSE FALL RISK ASSESSMENT CHART

	_									
Variables	Date	16/12/23	19/6/63							
	Time	4-36	14.15							·
History of falling	No	(6)	0	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	ک	0	0	0	0	0	0	0
(≥ 2 medical diagnosis)	Yes	(15)	(15)	15	15	15	15	15	15	15
Intravenous Therapy /	No	9	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		(0)	$\begin{bmatrix} 0 \end{bmatrix}$	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		(0)	(0)	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0		0	0	0	0	O	0_	O
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants,	No Yes	0 (15)	0	0	0	0	0 15	0	0	0
anti-hypertensives, hypoglycemics and psychotropics		\cup								
Total Score		50	450							
Low Risk (0 - 24)										
Medium Risk (25 - 44)	-			-						
High Risk (45 or above)	,									
Signature & Emp. No. of RN		High	OFF							-
Signature & Emp. No. of Sr. RN		N	R							
	<u> </u>	2000 -	24: Low	Risk; 2	5 - 44: N	/edium	Risk; 45	or abo	ve: Hial	Risk

		— <u>(</u>								
INTERVENTIONS	Date	17/2h	16/1/18							
· · · · · · · · · · · · · · · · · · ·	}	2/0	17.			<u></u>				
Tick as per the Risk Score	Time	1.5	14.15							
Low Risk Interventions (0 - 24)										
Familiarize the patient with the immediate surround			-							
Remind the patient to use call bell before getting ou						<u> </u>				
Keep the two side rails in the raised position at all t	imes for								ĺ	}
all patients regardless of age	:4L:- 4L	-					ļ		<u> </u>	
Keep the call bell, bedside table, water, glasses with patient's easy reach	ilmin ine	/								
Remove excess equipment or furniture to make	a clear					 			 	
path	u 0.0u.	' ˈ					İ		<u> </u>	
Keep the patient's bed in the low position at all times	s except				†					
during procedure										
Teach fall-prevention techniques, such as sitting	up for a		<i>-</i>						ļ	
moment before rising from the bed						ļ	<u> </u>			
Bed wheels should be locked		-								
Encourage family participation in the patient's care Ensure that floor of the bathroom is dry and not slipp		 			 	<u> </u>	<u> </u>		ļ	
Review medications for potential side effects the		 				ļ				
promote falls	inut UCIII									
Use safety belts during movement in wheelchair		/			 	<u> </u>				
The patients are not ambulated by themselves. The	ey are to	/			 	<u> </u>				
be ambulated only with assistance										
Medium risk interventions (25 - 44)					 					
Apply all the low risk interventions										
Tie yellow fall risk tag in the bed and Wheel chair / St									ļ	
Make sure that proper transfer precautions are in										
for heavy or debilitated patients in a bed or wheel on a toilet seat	cnair or								ŀ	
Use restraints and bed monitors as ordered by the c	doctor						-			
Allow the patient to ambulate only with assistance	200.01									
Consider peak effects of the medications that effects	cts level						<u> </u>			
of consciousness, gait and elimination when p	lanning						ļ			
patient's care										
Do not leave patients unattended in diagno	ostic or]					
treatment areas		<u> </u>							<u> </u>	
Accompany the patient while going to bathroom Advice the patient to use grab bars near the toilet, to	hathtub					<u> </u>	-			
and shower	bati itub,	_				}				
Make sure the family and other visitors understa	and the			<u> </u>					<u> </u>	
restrictions mentioned above										
High-risk interventions (45 or abovc)							<u> </u>		<u> </u>	
Apply all the low and medium risk interventions									ļ	
Tie red fall risk tag in the bed, wheel chair and stretc						<u> </u>	_		<u> </u>	
Locate the high-risk patients in a room close to the	nurses'									
station Answer these patients call bells as quickly as possit	hle			L			-			-
Provide a commode at bedside (if appropriate)	<u> </u>	' /			 		 			
Urinal/bedpan should be within easy reach (if appro	opriate)	/								
Encourage family members or other visitors to s		/					 			
them			/		ļ	<u> </u>			ļ	
If appropriate, consider using protection devices	s: safety									
belts		 6 -	<u> </u>	<u> </u>		ļ			<u> </u>	ļ
Signature & Emp. No.	of RN	W.W	(Ash							
Signature & Emp. No. of S	Sr. RN	A /	1			<u> </u>				
		V	2000				_			
	c	, or (י פ							

MEDWAY HOSPITALS

CODAMBAKKAM (HEART)

¹, 1st Main Road, United India Colony , Kodambakkam, Chennai, Tamilnadu, Inc. 044-2473 4455

care@medwayhospitals.com

Registration No : MHI202381326 Patient Name : BALASUBRAMANI

Age : 62 Gender : Male

Bill No : MMH/HM/IPH00528 Bill Date : 16/12/2023 3:19:35PM

Ward Name : RADIAL LOUNGE Bed Name : RL-1

NO DUE

Prepared By







MRD CHECKLIST

PARTICULARS	YES	NO
- IP Number allocated to each Patient	<u> </u>	
- Name, Age & Sex of Patient	7	
- General Admission Consent	5	
- Initial Assessment of Patient / Diagnosis		
- Nutritional Assessment by Consultant	<i></i>	
- Plan of care counter signed by the Consultant	<i></i>	
- Treatment Orders - Date, Time, Name & Sign.	5	
- Medication Order / Drug Chart - Date, Time, Name & Sign.	5	
- Vital Signs Chart (TPR Chart)	\sim	
- Intake Output Chart	<u></u>	
- Drug Chart (Duly filled)	S	
- Anesthesia Consent - (8 thing) - Date, Time, Name & Sign. of both Patient & Anesthetist	5	
- Anesthesia Assessment Sheet	H	
- Surgery Consent - (8 things) - Date, Time, Name & Sign of both Patient & Surgeon	5	
- Surgery Notes - Post Operative Plan	<u></u>	
- Pain Scoring System		
- Blood Transfusion if done		
- High Risk Procedures		
- A copy of the Discharge Summary	5	





Mr.BALASUBRAMANI

Patient Detai 62/Mule/MHI202381326

Name:

27/12/2023/IPH2023002613

UHID: DOB: DOA:

Dr.RAJESH.V



/IPD/2022/002 Medway Heart

Consultant: Every heart beat counts

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ADMISSION SLIP

		<u> </u>			
Admitting Doctor:	18. R 21 es	h.	Speciality:	CTVS.	
Advised Date & Time:	271121	23(0)	17-your.		
Provisional Diagnosis:			<u> </u>	Λ /	2
	CAI) _ (~	Ple va	s d du	en ·
Reason for Admission:		raement s	Surgical Ma	nagement	
ricason for Samusion		e specify details	· ·		;
Admission Type:	Day Care	ER	Ward		
	□ ICU		(Specify details)		
Surgery / Procedure Nam	e (if planned):	342			
Blood Product Requireme	ent: No Dy	es (Kindly specify	details of compone	nts required in spac	e below)
Expected Duration of Stay	r: "S	- 6day	<i>t</i> s '		
Expected Cost of Treatme	nt (as per-Financial (Counseling For	n):		The Contract of the Contract o
Payer: Self Insuran			JA 4.	,	
Instructions to Nurse (if a	avl:	- `	<u></u>	* * * * * * * * * * * * * * * * * * * *	
·		Adm	lt in	Priv	déroon
Any other Instructions (if	any):				
, ,	_				
		_			3
Doctor's Signature a 44	Name		Pog No	Ina	ed - 12/Time

MDr. V. RAJESH Reg No: 62794

For admission desk staff only:					
Room Category:	General Ward Single Room Twin Sharing Deluxe Room Suite Room Others				
Admission intimation Receipt Details		Admission Time in HIS			
Date	Time	Date	Time		
21/2/23	10-4400	27/12/23	11:46AM		
Source: DPD					
Front office Staff Signature	Name	Emp. No.	Date/ 1 Time		
Ste.	Name	2209	27/12/2> 11:46		
· ·	_				
	$oxed{H}_{oxed{m}}$	Dr. V. RAJES Reg. No. : 6270			



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Patient Details (Aug. MI.BALASUBRAMANI

Name: UHID:

62/Mulc/MHI202381326 27/12/2023/IPH2023002613

DOB: DOA:

Dr.RAJESH.V

Consultan



MHI/HOSP/2022/129

ADMISSION FORM

Marital Statu	s Full Address NO-186 2nd Short P.P. Can	Telephone Number		
Massic Occupation	Street P.P. Gard Amniji Kavai, Chennai - 29	9941476652		
Referred from	27esh 77/10/99@1194 21/24 7da	al No. of Days		
UNIT CONSTANCE MLC Yes No If Yes AR No.:				
	ICD Code			
TRIPU	25.1			
PATE	J24.9			
Posi	R94.3			
To	_			
NORI	50.1			
DIAG	Eug Tio			
DATE	OPERATION / PROCEDURES	ICPM Code		
28-12-23	OFF PUMP CORONARY ARTERY BYPASS CRAFTING SURGERY X 3 CRAFTS	36.13		
DATE	TYPE OF ANESTHESIA			
28.12.23	GENERAL SPINAL LOCAL REGIONAL	EPIDURAL		
DISCHARGE STATUS				
Cured	DISCHARGE STATUS ☐ Discharge at Request ☐ E	Expired < 48 hours		
Cured	DISCHARGE STATUS Discharge at Request Against Medical Advice			
	DISCHARGE STATUS Discharge at Request Against Medical Advice Absconded	Expired < 48 hours		
☐ Improve☐ Unchan	DISCHARGE STATUS Discharge at Request Against Medical Advice Absconded Transferred to	Expired < 48 hours Expired > 48 hours		

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
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 hospifal as agreed above, I hereby authorise the hospital to transfer me/the patient to any other hospital/institution for further treatment as deemed fit and proper by the hospital authorities.
I also acknowledge having been informed if the General Rules and Regulations of the Hospital and that all cash, jewellery and valuables belonging to the patient or theis attendants have been removed to a place of safety / handed over to the next of kin and I absolve the hospital of any responsibility with regard to any loss.
I have read out and explained the contents of the above to the Signatory in his vernacular .
சிகீச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்
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 செய்கிறேன்.
மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.
செவிலியா கையொப்பம் தேதி Signature of Admitting Nurse Date 27/12/2 5 Signature of the Patient / Relative / Gurdian

PRELATION ARTS

Nature of Relationship Daughtes



discharge.





Patient [] Mr.BALASUBRAMANI Name:

62/Malc/MHI202381326 27/12/2023/IPH2023002613

UHID: DOB: DOA:

Consultara





GENERAL CONSENT FOR ADMISSION

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

- 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.

Complete British States of the Complete States

	Signature / Thumb Impression* Name				Time
Patient `	Mai	N. Balasubramani	27	12/23	11:46
Surrogate/Guardian (if applicable #)	B. Raj i	B. RAJESWART (Write name and relationship with patient)	27	12/23	11:46
Reason for surrogate consent	Patient is unable to give consent to	because:			
Witness	/3 Lm/=	Bhuvaneswari	27/	12/25	11:40
Interpreter (if applicable)					

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



Mr.BALASUBRAMANI

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

Dr.RAJESH.V



MHI/ICU/2022/114

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ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

S. No.	PARAMETERS	MARK APPROF	
	Hemodynamic instability defined as		
ł	Pulse less than 40 or more than 150 beats/minute	,	
1	Systolic arterial pressure less than 80 mm Hg or 20 mm Hg below the patient's usual pressure		
	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		
Į	Acute myocardial infarction		
.]	Cardiogenic shock		
}	Complex arrhythmias requiring close monitoring and intervention		
Į	Acute congestive heart failure with respiratory failure and / or requiring hemodynamic support		
2 [Hypertensive emergencies		
1	Unstable angina, particularly with dysrhythmias, hemodynamic instability, or persistent chest pain		
Ţ	Post cardiac arrest		
	Cardiac tamponade or constriction with hemodynamic instability		
	Dissecting aortic aneurysms	·	
	Complete heart block		
7	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	<u></u>	
	Post Cardio-vascular Surgery		
	Following angiographic procedure		
}	Complication resulting from the angiographic procedure including any significant change in pulse in the	i , ,	
ł	affected extremity, neurologic changes, persistent bleeding, or persistent nausea and vomiting post-	'	1
5	procedure		<u>-</u>
Ì	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		
\dashv	Pulmonary System		
)	Acute respiratory failure requiring ventilatory support (Invasive / Non-Invasive)		
,	Pulmonary emboli with hemodynamic instability		
6	Patients in an intermediate care unit (HDU / Recovery room) who are demonstrating respiratory		
ł	deterioration Need for nursing / respiratory care not available in such intermediate care units		
}			·
}	Massive hemoptysis		
	пеэрнаслутаноге песонод плититель информация	<u> </u>	·
ļ	Renal failure		1
7	Oliguria or anuria for more than 12 hours		
' [Metabolic acidosis (pH < 7.1)		\
Ì	Patients requiring hemodialysis can be performed in ICU when the blood pressure is borderline		

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 with	_ 						
		molar state with coma and/or	more than 800 mg/dl						
ı	Other endocrine problems such as adrenal crises with hemodynamic instability Severe hypercalcemia (Serum Calcium more than 15 mg/dl) with altered mental status, requiring								
8	hemodynamic monitoring								
	Hypo or hypernatremia (Serum Sodium less than 110 mEq/L or more than 155 mEq/L) with seizures, altered mental status								
			dynamic compromise or dysrhythmias						
	Hypo or	hyperkalemia (Serum Potassi	um less than 2.0 mEq/L or more than 6.0 mE	q/L) with dysrhythmia:	sor				
		r weakness osphatemia with muscular wea	akness	 _					
	Гурорп		anicos	·					
		Signature	Name	Reg. No.	Date	Time			
Do	ctor	વકીયોત્ર	13-35						
S. No.		emodynamic parameters	PARAMETERS		1	RK ✓ AS OPRIATE			
2		. 	d with stable arterial blood gases) & airway pa	atent	1				
3		oxygen requirement (not more							
<u>4</u> 5		dysrhythmias are controlled	upport and vasodilators are no longer neces	ssary					
6		e of distal pulses		- -		 '			
7		of bleeding and hematoma at	puncture site	· -		-			
8	End of li	fe care pathway chosen							
		Signature	Name	Reg. No.	Date	Time			
Do	ctor	4	Av. Mavezn	119236	30/12/23	12.00			
			•		, 1				





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: 27/12/2023

: 02/01/2024

114



DISCHARGE SUMMARY

IP No. UHID

Name

: IPH2023002613

: MHI202381326

: Mr. BALASUBRAMANI

Age / Gender : 62 Years / MALE

Consultant

: Dr. V. Rajesh, MS, M.Ch (CTVS)

Senior Consultant Cardiothoracic and Vascular Surgery

D.O.S: 28.12.2023

D.O.A

D.O.D

Room No.:

DIAGNOSIS:

TRIPLE VESSEL CORONARY ARTERY DISEASE

PATENT LCX STENTS

ACS – UNSTABLE ANGINA

POSITIVE TMT - 19.08.2019

S/P PTCA + STENTING TO DISTAL AND PROXIMAL LCX - 20.08.2019

NORMAL LV SYSTOLIC FUNCTION – EF: 64%

TYPE II DIABETES MELLITUS

SYSTEMIC HYPERTENSION

SURGERY:

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 3 GRAFTS: LIMA TO LAD, LEFT RADIAL ARTERY TO DISTAL RCA, SVG TO DISTAL OM1 DONE ON 28.12.2023

BRIEF HISTORY:

Mr. Balasubramani, 62 years old male, a known case of Type II diabetes mellitus, Systemic hypertension, Positive TMT - 19.08.2019, S/P PTCA + stenting to distal and proximal LCX - 2019, ACS - Unstable angina, Triple vessel disease and patent LCX stents, Normal LV systolic function, has come for CABG. Patient was doing well with medications till I month ago when he developed chest pain – retrosternal, radiating to left shoulder, associated with palpitations and sweating. H/o breathlessness on exertion. H/o bilateral leg swelling (+). Initially, he went to Chennai Port Trust where he was advised Coronary Angiogram. He was referred from Chennai Port Trust to Medway Heart Institute on 16.12.2023 and underwent Coronary Angiogram which showed Triple vessel disease and patent LCX stents. He was 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 Syncope. No H/O CVA, CKD, BA, seizure disorder or Hypothyroidism.

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Mogappair

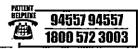
Kodambakkam

044-2473 4455

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Medway Group of Hospitals

Kakinada 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





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NAME: Mr. BALASUBRAMANI UHID: MHI202381326 IPNO: IPH2023002613

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

TEMP

96.5° F

HR

80bpm

BP

130/80 mmHg

SPO₂

94% in room air

CVS

S1S2 (+)

RS

BAE (+)

Abdomen

Soft, non - tender

CNS

NFND

BLOOD INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN	14.0	Male: 13.7 - 17.5	gms%
		Female: 11.2 - 15.7	
HAEMATOCRIT	41.7	39-52	%
TWBC	7180	4000 - 10000	Cells/Cumm
NEUTROPHILS	59.0	40-70	%
LYMPHOCYTES	29.5	20 - 40	%
EOSINOPHILS	4.9	0 - 6	%
MONOCYTES	5.6	0 - 6	%
BASOPHILS	1.0	0 - 2	%
PLATELET	249000	Male: 1.5 - 3.5	Cells /cumm
		Female: 1.5 - 3.7	
Urea	23	14 - 40	mgs/dl
Creatinine	0.80	Male: 0.7 - 1.2	mgs/dl
		Female: 0.5 - 1.0	<u> </u>
		Child: 0.2 - 0.8	
Sodium (Na+)	139	135 - 145	mmol/l
Potassium (K+)	4.43	3.4 - 5.5	mmol/I
T. Bilirubin	0.43	0.2-1.0	mg/dl
D. Bilirubin	0.16	0.00 - 0.4	mg/dl
I. Bilirubin	0.27	0.4-0.6	mg/dl
S.G.O.T	23	<38	U/L
S.G.P.T	30	<41	U/L
ALP	133	Adult: 42 - 141	U/L
GGT	43	Male: 10 - 45	U/L
,		Female : 5 - 32	
Total Protein	7.1	6.0 - 8.0	gm/dl
S. Albumin	4.2	3.5 - 5.0	gm/dl

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





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NAME: Mr. BALASUBRAMANI UHID: MHI202381326 IPNO: IPH2023002613

PROTHROMBIN TIME	11.5	Normal: 0.9 - 1.5 INR Therapeutic Level Myocardial Infarction: 2.0 - 3.0 Deep Vein Thrombosis: 2.0 - 3.0 Pulmonary Embolism: 2.0 - 3.0 Artificial Cardiac Value: 3.0 -4.5	
INR	0.9	Recur.Systmic Embolism: 3.0 - 4.5 INR	
HBA1C	11.7	Normal: Below 6.0 Good control: 6.1-7.0 Fair Control: 7.1-8.0 Unsatisfactory: 8.1-10.0 Above 10: poor control (GHB is an index of your blood Sugar control for the past (3 months)	%
T.S.H	1.11	Adult: 0.25 - 5.0 New born-4days: 1.0-39.0 Child upto 14yrs: 1.0-9.0	ulU/ml
Т3	150	"Adult: 60 - 152 New born - 4 days: 96 - 730 1 - 11 Months: 102 - 243 1 - 9 yrs: 89 - 237	ug/dl
T4	11.0	"Adult: 4.6 - 9.3 New born - 4 days: 11.0 - 21.3 1 - 11 months: 5.8 - 16.1 1 - 9 yrs: 6.3 - 13.16	ug/dl

ECG: HR – 82bpm, sinus rhythm, LVH (+)

ECHO: S/P PTCA, EF CALCULATED BY SIMPSON'S METHOD: LV EDV: 123ML, ESV: 41ML, EF: 66 %, AORTIC GRADIENT - MAX GRADIENT - 5 MM HG, MEAN GRADIENT - 3 MM HG, CONCENTRIC LVH, ALL CHAMBERS NORMAL SIZED, NO REGIONAL WALL MOTION ABNORMALITY, NORMAL LV SYSTOLIC FUNCTION - EF: 64%, GRADE I DIASTOLIC DYSFUNCTION, NORMAL RV SYSTOLIC FUNCTION, RV TDI: 16CM/S, TAPSE: 20MM, IAS / IVS INTACT, AORTIC VALVE SCLEROSIS, TRIVIAL AR, NO AS, OTHER VALVES ARE STRUCTURALLY NORMAL, TRIVIAL MR, TRIVIAL TR, NO PAH, IVC NORMAL IN SIZE AND COLLAPSING, NO CLOT / VEGETATION / EFFUSION.

CAROTID DOPPLER: Normal bilateral carotid and vertebral Doppler study.

CXR: PA film, Lung fields clear.

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

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MHI/HOSP/2022/1





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NAME: Mr. BALASUBRAMANI UHID: MHI202381326 IPNO: IPH2023002613

COURSE IN THE HOSPITAL:

Mr. Balasubramani, 62 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, LEFT RADIAL ARTERY TO DISTAL RCA, SVG TO DISTAL OM1 ON 28.12.2023. He was extubated on table in Operation theatre. He was shifted to SICU with stable hemodynamics and nil supports. 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

88/min

BP

140/80mmHg

SPO₂

94% in room air

POST OP INVESTIGATIONS:

BLOOD:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN 10.7		Male: 13.7 - 17.5	gms%
		Female: 11.2 - 15.7	
HAEMATOCRIT	32.2	39-52	%
TWBC	11220	4000 - 10000	Cells/Cumm
NEUTROPHILS	67.7	40-70	%
LYMPHOCYTES	22.3	20 - 40	%
EOSINOPHILS	3.9	0 - 6	%
MONOCYTES	5.7	0 - 6	%
BASOPHILS	0.4	0 - 2	%
PLATELET	292000	Male: 1.5 - 3.5	Cells/cumm
		Female: 1.5 - 3.7	
Urea	46	14 - 40	mgs/dl
Creatinine	1.00	Male: 0.7 - 1.2	mgs/dl
		Female: 0.5 - 1.0	
		Child: 0.2 - 0.8	
Sodium (Na+)	138	135 - 145	mmol/l
Potassium (K+)	4.37	3.4 - 5.5	mmol/l

ECG: HR – 86bpm, sinus rhythm, no fresh ST – T changes.

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Institute of Pulmonology 044-2473 4451

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NAME: Mr. BALASUBRAMANI UHID: MHI202381326 IPNO: IPH2023002613

ECHO: S/P CABG, ALL CHAMBERS NORMAL IN SIZED, NO REGIONAL WALL MOTION ABNORMALITY, NORMAL LV SYSTOLIC FUNCTION, EF: 59%, NORMAL RV SYSTOLIC FUNCTION, RV TDI: 9CM/S, AORTIC VALVE SCLEROSIS, OTHER VALVES STRUCTURALLY NORMAL, IAS/IVS INTACT, IVC NORMAL IN SIZE AND COLLAPSING, AORTIC GRADIENT -MAX GRADIENT - 2MMHG, MEAN GRADIENT - 1MMHG, GRADE I DIASTOLIC DYSFUNCTION, TRIVIAL AR, NO AS, TRIVIAL MR, TRIVIAL TR, NO PAH, MILD LEFT, MINIMAL RIGHT PLEURAL EFFUSION, TRACE PERICARDIAL EFFUSION ANTERIOR TO RV, NO CLOT/ VEGETATION.

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

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

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

Kakinada

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





(A Unit of United Alliance Healthcare Pvt Ltd)

NAME: Mr. BALASUBRAMANI UHID: MHI202381326 IPNO: IPH2023002613

ADVICE MEDICATIONS:

SI	NAME OF THE	•		FRE	QUE	NCY		RELATIONSHIP	
NO.	DRUGS WITH GENERIC NAME	STRENGTH	DOSAGE	M	A	N	ROUTE	WITH MEAL	DURATION
	TAB. CLOPITAB A (CLOPIDOGREL + ASPIRIN)	1 TABLET	75MG / 75MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. FORTIUS (ROSUVASTATIN)	1 TABLET	10MG	0	0	2	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. BETALOC (METOPROLOL)	1 TABLET	25MG	I	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB. DILZEM – SR (DILTIAZEM)	1 TABLET	90MG	1	0	ī	ORAL	AFTER FOOD	X 6 WEEKS
5/	TAB.LASILACTONE (FURSEMIDE + SPIRONOLACTONE)	1 TABLET	50MG/ 20MG	1/2	0	0	ORAL	AFTER FOOD	X 2WEEKS
6	TAB.PARACIP (PARACETAMOL)	1 TABLET	500MG	1	0	1	ORAL	AFTER FOOD	SOS (IF PAIN OR FEVER)
~	TAB. NEUROBION FORTE	1 TABLET		1	0	0	ORAL	AFTER FOOD	TO CONTINUE
8~	TAB. METHYCOBAL (METHYLCOBALAMIN)	1 TABLET	500MCG	0	0	1	ORAL	AFTER FOOD	X 10 DAYS
, ·	SYP. CREMAFFIN PLUS (SODIUM PICOSULFATE+ LIQUID PARAFFIN + MILK OF MAGNESIA)	I5ML		0	0	I	ORAL	AFTER FOOD	BED TIME (IF CONSTIPATI ON)
10	TAB. BEPLEX FORTE (ANTIOXIDANTS +MULTIVITAMINS+ MULTIMINERALS)	1 TABLET		1	0	0	ORAL	AFTER FOOD	1 MONTH
11	SYP ALEX PLUS (DEXTROMETHORPHA N HYDROBROMIDE + GUAIFENESIN + PHENYLEPHRINE + CHLORPHENIRAMINE MALEATE)	10ML		0	0	1	ORAL	AFTER FOOD	BED TIME (1 WEEK)
12	TAB.ANXIT (ALPRAZOLAM)	1 TABLET	0.5MG	0	0	1	ORAL	AFTER FOOD	X 5 DAYS

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#9, 1st Main Road, United India Colony, I	Kodambakkam, Unennai	- OUUUZ4. Tel ; U44 - 43 IU 8939

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(A Unit of United Alliance Healthcare Pvt Ltd)

NAME: Mr. BALASUBRAMANI UHID: MHI202381326 IPNO: IPH2023002613

DIABETIC MEDICATIONS:

SI.	NAME OF THE DRUGS	STRENGTH	DOSAGE	FRE	QUEN	CY	ROUTE	RELATIONSHIP	DURATION
NO	WITH GENERIC NAME			M	A /	N		WITH MEAL	
	<u> </u>				'.				
~	TAB. DAPAVEL	1 TABLET	10MG	1	0	0	ORAL	AFTER FOOD	ТО
	л (DAPAGLIFLOZIN)								CONTINUE
2.X	∼ TAB. GLIZATO	1 TABLET	80MG	1	0	1	ORAL	BEFORE	ТО
	✓ (GLICLAZIDE)							FOOD	CONTINUE
3~	TAB. JANUMET	1 TABLET	50MG/	'1	0	1	ORAL	AFTER FOOD	ТО
	(SITAGLIPTIN +		500MG						CONTINUE
	∧ METFORMIN)							•	
4~	INJ. WOSULIN			25U	25U	25U	S/C	BEFORE	TO
	(INSULIN							FOOD	CONTINUE
	ISOPHANE/NPH (70%)								
	+ HUMAN								
	INSULIN/SOLUBLE								
	INSULIN (30%))								

DISCHARGE ADVICE			
DIET	HIGH PROTEIN, LOW SALT		
	LOW FAT / DIABETIC DIET		
PHYSICAL ACTIVITIES	RESTRICTED.		
FLUID RESTRICTION	NIL		
-	REVIEW WITH		
REVIEW	DR. V.RAJESH AFTER 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 emelgency Contact: Medway Hospitals @ 044 -43108959.

Typed by: Kalai

Mogappair

CONSULTANT SIGNATURE

Dr. V. Rajesh, MS, M.Ch (CTVS)

Dr. V. RAJESH Reg No: 62794

Senior Consultant Cardiothoracic and Vascular Surgery

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

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044-26530011 | 044-27426829 | 04146-242000 | 044-2473 4455 | 0884-2333367 044-2473 4455 E-mail: info@medwayhospitals.com | Website: www.medwayhospitals.com | CIN: U74900TN2011PTC083665





Mr.BALASUBRAMANI

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

Dr.RAJESH.V





INPATIENT INITIAL ASSESSMENT

INPATIENT INTERACTORISMENT	
Date: 271225 Time of arrival in ward: 1:30 pm	
Allergies (if Yes, specify details):	
Drugs Yes No	_
Blood Transfusion	_
Food Yes No	_
Others	_
Vital Signs: Temp: 96 (°F) Pulse / HR: 8 (beats/min) BP: 130 / 80 (mmHg) Respiration: 0 (breaths/min) SpO ₂ : 95 (%) Height: 168 (cms) Weight: 18.2 (kgs) BMI: 17-74g/mz	
Pain: Yes No. If Yes, Score: 7/10 Pain Scale Used: Numerical Rating Scale (>12 years) CPOT (ventilator / comatose) Duration: Location: Pain Character: Dull Aching Sharp Stabbing Shooting Burning Referred / Radiant Pain	
CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS	-
CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS Pt was admitted with Comptaint of chest pair (Retroster) Radiating to RF shouldes associated z palpitation for past- month.	yal
PAST MEDICAL HISTORY (with duration of illness): Diabetes Mellitus: Ses No. If Yes, duration: 2040 Hypertension: Ses No. If Yes, duration: 6 to 1/2 Hypertension: 1/2 Hyperte	
Others: K/c/o Pyslipi demia./CAD -TVA	—
Past Surgical History: - Ho PTCA + stent -> Distal & proximal Lux (20 - H/o Lap. Appendiculomy (2010) - H/o CAG (16/12/23)	,1-4

Pro	esent Medication (for Medication R	econcilia	tion):			
S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
}-	TAB. TICAGREWS	90mj	Pho	10-9	23/12/23	☐ Yes ☐ No
2.	TAB. ECOSPRIN	Timg	plo	0-90	23/12/23	☐ Yes ☐ No
g.	TAB. TELHA	વળપ	Plo	009	23/12/23	☐ Yes ☐ No
4.	TAB- ANGIPLAT	& 5m	ρlo	109	27/2/23	☐ Yes ☐ No
<u>ن</u> ک	TAB. DYTOR PLUS	5/5017	, plo	1000	27/12/23	☐ Yes ☐ No
6.	TAB. ATORVA	2 pmg	Plu	0-0-9	27/12/23	☐ Yes ☐ No
7.	TAB. HETHYL COBALAYA	Doney	plo	orf	26/12/23	☐ Yes ☐ No
8	TAB. GOBEN	300m	ρlo	D-H-J	26/12/23	☐ Yes ☐ No
9.	TAB. NEUROBION FORTE	itab	ρ/0	0-01	26/12/23	☐ Yes ☐ No
10.	TAB. ISONIT ,	5mg	ρlo	001	26/12/2	☐ Yes ☐ No
,	Personal / Social History (Tick whichever is applicable)					
Sr	festyle: Sedentary Active noking: Yes Mo Alcohol	Occup	/	Recreationa	I Drûg Use: ☐ Yes ☐ I	No .
Me	nstrual and Obstetric History (to b	e filled up	o for fema	le patients):		·
		`	,	^{7,8}	ı	
Pa	General Physical Examination: Pallor: ☐ Yes ☐ No					

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SYSTEMIC EXAMINATION
cys:
SS (4)
Respiratory System:
BAE (1)
Gastrointestinal System:
Joft, Bs (4)
Central Nervous System:
Urinary / Reproductive / Locomotor System:
Skin / Opthalmic / ENT
Suspected of contagious disease: Yes No Immuno compromised status: Yes No Isolation required: Yes No, if yes, Contact Airborne Droplet
Psychological Evaluation: ☐ Normal ☐ Anxious ☐ Depressed ☐ Others:
Nutritional Screening (ESPEN Guidelines for Nutritional Screening - NRS 2002):
Weight loss within the last 3 months? Yes 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: Drubable Angina CAD-TVD Jdm 18+19N pyslipidemia
Plan of Care: Plan - CABG tomorrow
Plan of Care: — plan - CABG tomorrow — cheek (BG TD) — to preop order is made was sold a company — tonitor vital
- Honitor vital

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Investigations Advised:				v	=4,"
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Diet Advice:					
☐ Nil per Oral ☐ Clear liquid diet	☐ Normal liquid		_	liquid diet	в.
Semisolid diet Seft solid diet	South Indian	normal diet	_	lian normal c	Jet
Neutropenic liquid diet Others:					_ _
Early Discharge Planning (fill in those which are a	appropriate at thi	s stage):	PFE: Pa	tient Family	Education
Special support needed at home	☐ Yes ☐ No	If Yes, PFI	E done		
Home equipment anticipated	☐ Yes ☐ No	If Yes, PFE done and equipment advised			
Physiotherapy at home anticipated		cated on physi	ical limitation	s, if any	
Wound care needs anticipated at home	Vound care needs anticipated at home Yes No If Yes, educated on signs on infection				
Pain Management	☐ Yes ☐ No If Yes, PFE done and medication advised				
Special Dietary needs Yes No If Yes, educated on dietary restrictions, food drug interactions and allergies		s, food			
Continuous / ongoing care anticipated	continuous / ongoing care anticipated		fongoing		
Other special education need, i.e.:					
Nature of post hospital needs like patient safety, infection control, fall risk, etc, addressed	☐Yes ☐No	If Yes, spe	ecific education	given	-
Others:	· ·	-			
` /					
Signature	Name		Reg. No.	Date	Time
Resident Doctor Dr. Anbarasu Lienarira	DR.S.J.		170318	27 12 23	13:30
Consultant Reg No: 55478	y DR. RA		CHAPT TO	बर्मारिक	12:00
Patient Attendant 2. 200	Relationship (/)		13.30		







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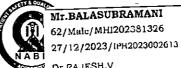
DOCTOR'S PROGRESS NOTES

<u> </u>	DOCTOR 3 PROGRESS NOTES	
DATE	NOTES	
, ,		
27 12 23	- SIR - Dr. Sis Flago (Duo)	
4:00pm	1	
1 -	1. CAG done (TVD) / Dyshjoi	denis _
	· · ·	
	Plan for CARG (28/12/28)	
	pt. resourced. No yor cor/ cho	1 pais
	0/E: conceru, oventid, appirle	
	S/E: CME: C162 (F)	
	Pa: RAE (7)	
	P/A: -co/L	
	Adrice:	
	- Vitul mon	tori).
	- Follow ups de	up charts
	Dallare	
+ 3 d (4 + 4)	- NPO from 1	2:00 cm (20/12/23)
		[20/12/23]
<u> </u>	- Irgans OS	
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	thy.	
	Tandun.	

DATE	NOTES
	S/B Dr. Mohamed Hydros
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Dr.Rajesh.v

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	DOCTOR'S PROGRESS NOTES
DATE	NOTES
28/12/23	S/B DO-ADMENYA
8:50AM	
8.50	patient revieused.
	no specific complaints
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	pt posted for CABLY today.
A	poe-op ordenstolland.
KM	shift to colored on call.
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	DOCTOR 5 PROGRESS NOTES
DATE	NOTES
28/12/23.	Mr. Balasubaamani underwent opiAB x 3 grafte.
13:45	He use shifted to sun & four hemodynamica
	HR: Bolmin
	BP: 145 180mn H
	CVP: 8 mg
	SPO_: 1001 on 6 liter Ormack.
	Supporte: Nil
	Plan: ARB, ACT XIQ
	Morilos vitale
<u> </u>	De Rojesh PA: lai cll MH10028
	PA: Rai cl
	M H10028-
	·
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DATE	NOTES
29/12/2023	2/B: Dr. Poparasu Dr. Pajesh Dr. proven
8.00	
	lle: opcob x 2 grafts.
pop#1	patient comfortable
46-11.2	off: conscious, oriented, Afebrile
u - 34	· Bp - 122 /50 mm Hg
N - 0.85	-HR - 112 Bpm
134 <u>134</u>	·spo, -96% on nasal prongs
K - 3.46	.910 -2359 ml / 2049 ml : Ral (+)310 ml
	on ucaff
2BS -227 mg	de Adequate virine output
	· rolerating jeeds
PBY	peripheries warm(t)
PH-7453	supports: nu
	Total drain: 400 mL
po61.2	
+103-23-9	
BE - 0.0	
	Plan
	· RF 2.2 lohns / day
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	· chat Phytin t Sp. romely
_	· Mobiline
	· Nebular
	T. HETOPRED AL 12. Sing tool
<u> </u>	T- GLY ZATO GO 1-0-1 (RF)
	- TANUMET 50)500 1-0-1 (BF)
	·T· DAPANEL long 1-0-0 (AF)
	· T. PRECAMAIN 75mg 101
_	Shell to us I







MHI/IP/2022/041 Mr.BALASUBRAMANI 62/Male/MH20000

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

Dr.RAJESH.V



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	DOCTOR'S PROGRESS NOTES
DATE	NOTES
30/12/23	S/B Dr. Ambaran / Dr. Rajet / Dr. Prevan
	S/P OPCARA A 3 quelto POD-2
3/0 - 2640	pt convers, oruntil
13% - 10-9	130 - 140/82 mm ltg
W - 3-8	572 - 92 7 in RA
	Tolenting and feet
	Plan RF 2.2 lubrus / day
	· Remove lines . Chest Physics & spromaty
	· Mobilese
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DATE	NOTES
	5/8 Dr. Mohamad hydroms
30/12/23	
10 gm	Por OP Case of OBG & Squafts Por-2- Repairt Connus Omendet. Yelside. Vitals.
	85Q-2
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Mr.BALASUBRAMANI

62/Malc/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V

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	DOCTOR'S PROGRESS NOTES
DATE	NOTES
31-12-23	5/B DO. Provilen CTVS
10-00Am	Patient sevieuse.
	Daula
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	to reduce Diwretics Forgu
	- T. Frisemide Homa 1-1-0 to
	T. Fousamide gamg OD.
701 1	- Rest Continue the same.
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31.12.23	6 B Do. Anostogo Mohamed hydron
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	Pop. 3.
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Mr.BALASUBRAMANI 62/Malc/MHI202381326 27/12/2023/IPH2023002613

Dr.Rajesh.v

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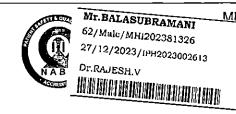
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	DOCTOR'S PROGRESS NOTES
DATE	NOTES
	
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DATE	NOTES
11124	3/B Dr. Anusung
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11-00AM	patient devieux
11 00	clo' pain in the subgicalite
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100D-19	DE conscious, oriented
	Of conscious, oriented
Vitals stable	S/E C14-S, S2(f)
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11/124	0
	Post op case of OPOGOS x 3 grafts POD-14 Potient Connan Orrented State State
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DOCTOR'S PROGRESS NOTES

	DOCTOR STROOKESS TROTES
DATE	NOTES
2/1/24	S/B. Dr. Still R. Como)
11:15Am	
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1. Bob	
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	· —
	DIM DIM
<u> – </u>	103675
	



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.BALASUBRAMANI 62/Malc/MHI202381326 Name: 27/12/2023/IPH2023002613 UHID No.: Dr.RAJESH.V Ward: B.S. A.S. Bed No. Clinical Diagnosis: Proposed Procedure: Identification Band on Hand Checked? 1. 2. Surgical consent Signed? a. Special Consent signed if required. Anesthetist Consultation (If required?) 3. History AND Physical Onchart? 4. b. Weight. 78.21 Allergic to drugs? 5. Surgical Preparation done? 6. 7. Blood Grouping & Rh Typing B. 8. 9. Investigation X - Ray 10. **TPR Chart** 11. Temp 95.5°F BP 154 84 RR 20 Time Voided 12. a. Retention ☐ Yes 13. Enema ☐ Yes

			
14.	a. Prosthesis Removed	<u>'</u>	, ,
	b. Plates present Removed		``~
	c. Contract Lenses Removed ☐ Yes ☐ No / ☐ Not Applicable		
	d. Dentures Removed ☐ Yes ☐ No / ☐ Not Applicable	ľ	
15.	Valuables and Jewellery Removed	_	
	☑ Yes ☐ No Secured ☑ Yes ☐ No		
16	Pre-Operative Medication Admistered		,
16.	/ ()	· `	
_ .	a. Time b. Nurse b. Nurse		
17.	Blood Transfusion requisition Onchart		
18.	X-Ray		
	ECG/ECHO I & Creening Folo Report -> (1)	<u> </u>	
	Ultra Sound CATOLICA DODDER PODON->(1)	~	
	C.T. Scan		
	MRI Scan		
	TMT		
	Medication		
	27/12/23		
	T. PAN HOMG) GIVEN		
	T. ALPRAX O.SMC AT. 21.00 Pin		
	28 12 23		
	THE MORPHINE SMG & GIVEN		
	Others TMT. PHENARGAN 125MG AT :8-30	~	
	J	**.	
		:	

Nurse Signature

Mr.BALASUBRAMANI 62/Male/MHI202381326

27/12/2023/1PH2023002613



Dr.RAJESH.V

MHI/NUR/2022/048

,	NI	JRSES PROGRESS NOTES					
Date & Time	(Observations / Action		Signatu	re with E	mp No.	
28/12/23	CTOT R	ECEIVAL REPORT					
@	Sheet	woo To CTOT With Blue Op Fil					
9.10	ECG: LECHO: ECHO: CT FILE:	1 X-RAY: \ ANGIO	CD: With				
	Patient Posted For Procedu	Iros AAD			QL_		
	Under Anesthesia: 100	CIBVI		~ ~	1200	_	
	Allergy Status: NKDA						
		THE WATER FULL			<u> </u>		
	WITAL SIGN:	10 - APPENDECTORY-	10x(2019)			
	TEMP: 87	CHR: 71 Phushos: d31/ Bb;	31187MMH9				
		SHIFTING REPORT					
28/12/23	Case Sheet Along With	To SDOWWith Blue Op	File And				
0	*Surgery Safety Check Lis *Intra Operative Record	st					
13-30	*Nurses' Record *	\ X-RAY: \ ANGIO C					
	ECG: \ ECHO:		3/-				
	CT FILE: ←		20 8-1	· 			
	Patient Posted And Underv Under Anesthesia: (
	Procedure: OFCABNZUMBE LIMA LAD, SVN JOM Drain tube size and placement: Drain tube size and placement:						
	Drain tube size and placem Pacing wire placement: Pre						
	Implants:						
	Cautery burn/skin peeling/						
	Site:						
	VITAL SIGN: TEMP: 27 C HR: 65 bpm	5PO2: 1001, ВР: 141 171 MM	of Ug				
	Notes:		,				
· .	Signature	Name	Emp. No.	1	Date	Time	
Document endorsed by	180aluz	M. SASPLWMAR	OGTHM	<u>B1</u> 28	10123	V3*89	



Mr.BALASUBRAMANI

62/Male/MHi202381326 27/12/2023/iPH2023002613

Dr.RAJESH.V





CONSENT FOR ANAESTHESIA SERVICES

BALASUBA	AMAN)	the patient or the representative of patient have,
☐Been explained this co	ned the current clinica nsent form in Englis	al condition of me/my patient h, which I fully understand and understood the information provided about サビル もソウムの - CRAF コルの
(full name of operation procedur	e given below in this o	consent form)
expected outcome and what needed for this operation, so the lithas been explained to me the with anaesthesia can occur sensation, loss of limb function. I understand that these risks at 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 sean anaesthesia. It has been may be needed explained to me without sedation, and the lithas been may be needed explained to me without sedation.	could happen if my of that my doctor can perhat all forms of anae and include the rerest, paralysis, stroke, to apply to all forms of a upe of anaesthesia. It is an anaesthetic technof procedure, my doctor that sometimes an aucceed 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. Sthesia involve some risks. Although rare, unexpected severe complications note possibility of infection, bleeding, drug reactions, blood clots, loss of orain damage, heart attack or death. Inaesthesia 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. Inaesthetic 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 CU Admission / Recovery There
General Anaesthesia	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
	Denems	- 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 reedle / 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

	egional Anaesthesia	Expected Results	Temporary loss of feeling and / o	or movement of a limb		,
☐ With Sedat ☐ Without Se		Technique	Drug injected into veins of arm of			
Alternatives		Risks	Infection, convulsions, persiste		_ 	vessels
I	or Nerve Block		- Pain Free	_		
☐ Others		Benefits	- Safer under certain conditions			
Monitore	esthesia care	Expected Results	Decreased anxiety and light sec	dation similar to norma	al sleep	
(with sed	acameala care	Technique	Drug injected into vein of arm		·	
<i>Alterna</i> ! □ Ger ana	esthesia	Risks	Prolonged sedation, need for a	rway control	•	
Spinal / Epid		Benefits	Anxiety free; Early discharge	-		
Monitored Ana	nesthesia Care	Expected Results	No changes in the system			:
Alternatives	ori)	Technique	None			
☐ General ana ☐ Mild Sedatio		Risks	Patient may have pain and anxiety			
Others)fi	Benefits	Early discharge	<u> </u>		
 Potential long term negative effects on memory, behaviour and learning with prolonged or repeated exposure to general anaesthesia / moderate sedation / deep sedation during pregnancy and in early childhood 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 For the above mentioned operation(s) / procedure(s) that I have been made aware of, I give my consent voluntarily to doctor 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. I, the above named Patient / named patient's representative, do further hereby declare that I am about 18 years of age as on the 				as on tor for tential		
			consent without any fear, thre	at of false miscorie	Date	Time
Patient		Smon_	N. BALASUBR	AMANT	22/12/16	1/4,2,-
Surrogate/Guare	dian P.Va		B. Rayeswau / M. Write name and relation	aughter.	291	1/4.2 _
(парриссые п)	Patient is un:	able to give conse	- l-' 	snip with patient)	27/12/23	773
Reason for surrogate conse	1	ubic to give conde				
Witness	Post		Paviller		27/12/23	Kr 25
Interpreter (if applicable)						
I, the unders	* Right Hand for Males & Left Hand for Females # Only if Patient is a minor or unable to give consent I, the undersigned doctor, have explained the nature, potential risks and complications, intended benefits, expected post-procedure course, and possible alternatives to the planned 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	Josephy		.A. S. SYNESTER	43570 .	27/12/23	14,25
	40	•				

் நரம்பு மண்டலம் மு	யக்க மருந்து	் எதிர்பார்க்கப்படும்	۱I.				
🔲 மயக்க மருந்து		முடிவுகள்	22.600	riaq மற்றும் ஒரு குறிப்பிட்ட மூட்டு ———————————————————————————————————			
மயக்க மருந்து இல்லாமல் மாற்றுகள்		நுப்பம்	<u></u> 9т С	ானிக்கேயைப் பயன்படுத்தும் பே ————————————————————————————————————	ாது கை அல்லது கை ந	நரம்புகளில் செலு <u>த</u> ்	தப்படுகிறது 👡
🗌 பெரிய / சிறிய	நரம்பு தொகுதி	அபாயங்கள்	தொற்	று, வலிப்பு, தொடர்ச்சியான உண	ர்வின்மை, மீதமுள்ள எ	வலி, இ <u>ரத்</u> த காயங்க	ளுக்கு காயம்
☐ பொதுவான ம ் ☐ மற்றவை	பக்க மருந்து	நன்மைகள்) இலவசம் நீபந்தனைகளின் கீழ் பாதுகாப்ப	ന്ത്യയ		
கண்காணித்த மயக் (மயக்கத்துடன்)	க மருந்து கவனிப்பு	முடிவுகள் எதிர்பார்க்கப்படும்		ரண தூக்கத்தைப்போன்ற கவமை		து வருகிறது	
<u>மாற்றுகள்</u>	.	நுட்பம்	கையி	ன் நரம்பில் மருந்து செலுத்தப்படு			
☐ பொதுவான மயக் ☐ மக6கலம்ப / இவ்	கை மருந்து விடைவெளி மயக்க மருந்து	அபாயங்கள்	நீண்ட	கால மயக்கம், காற்றுப்பாதை கட	டுப்பாடு தேவை		
🔲 மற்றவை	5,24	நன்மைகள்	கவை		யேற்றம்		
கண்காணித்த மயக் (மயக்கம் இல்லாமல்		முடிவுகள் எதிர்பார்க்கப்படுப்	கணி	னியில் மாற்றங்கள் இல்லை		_	_
<u>மாற்று</u> கள்		நுப்பம்	இல்ன				
☐ பொதுவான மய ☐ இலேசான மயக்		அபாயங்கள்	நோய	ாளிக்கு வலி மற்றும் கவலை இரு	க்கலாம்		
🔲 மற்றவை		நன்மைகள்	ஆரம்	ப வெளியேற்றம்			
# நினைவாற்றல், ந பருவத்தீல் ஆழு# நான் / மேற்கூற்	மான மயக்கத்துடன் நீ இய நோயாளி / பெயரி	லில் நீண்டகால எத் ண்ட அல்லது மீண் பப்பட்ட நோயாளிய	பின் பிர	விளைவுகள் பொது மயக்க மருந்து ஈடும் மீண்டும் வெளிப்படுதல் தீநீதீ, இந்த வடிவத்தீல் கைபெழு கு மேற்பட்டவன் என்று இதன்மூல	த்திடப்பட்ட தேதி, மன ரி		
டாக்டர் (டாக்டர்) டி. அ: நோயாளியிடம் முழுக நான் / மேற்கூறிய ரே	ல்லது டி-யில் கூறப்பட் மயாக அறிந்தீருக்கிற நாயானி / பெயரிடப்பப்	ட செயல்பாடு / ந ார். சாத்தீயமான ச ட நோயாளியின் ப	டைமுறை அபாயங் விரதிநிதி,	ிட்டது. நான் தானாக முன்வந்து எ றயை செய்வதற்கு) அறுவை சிகீச் கள் மற்றும் சிக்கல்கள் மற்றும் சா இந்த வடிவத்தில் கையெழுத்திடப் 'புதல் அளிக்கீறேன் என்று மேலும்	சை செயல்முறையை த்தியமான மாற்றுகள் பட்ட தேதீ, மன ரீதியாக	ச் செய்வதற்கான டா 6 18 ஆண்டுகள் நிர	·
	கையொப்பம் / ச	கட்டை விரல் பதிவு	*	பெயர்		தேதி	நேரம்
நோயாளி						_	
நோயாளிகளின் பிரதிநிதி பாதுகாவலர் (பொருந்தும் என்றால்)	1/			(நோயாளியுடன் பெயர் மற்றும்	் உறவை எழுதவும்)		_
நோயாளிகளின் பிரதிநி சம்மதத்திற்கான காரணம்		தல் அளிக்க முடிய	பவில்லை) ଗ୍ରନ୍ତେଶୀର୍ଭ			
சாட்சி							
மொழிபெயர்ப்பாளர் (பொருந்தினால்)							
நான் நியமிக்கப்பட்ட ம வகும் நடைமுறைகள்	ஞத்துவர், இயல்பு, சாத் மற்றும் தீப்பமிடப்பட்ட	தியமான அபாயா செயல்பாடூ/ நடை	ங்கள் மற் _முறைக்	 ஹாவிட்டால் மட்டுமே ஆண்களுக் றறும் சிக்கல்கள், நோக்கம் கொன் கு சாத்தியமான மாற்றுகள், நோ ராகப் புரிந்து கொண்டார் என்று நா	னட நன்மைகள், எதிர்ப யாளி / நோயாளி பிர	ார்க்கப்பட்ட பின் நக	மடமுறைக்கு
	கையொப்பம்	டை	யர்	-	பதீவு எண்	தேதீ	நேரம்
பெறப்பட்ட ஒப்புதல்							



(A Unit of United Alliance Healthcare Pvt Ltd)

X



Mr.BALASUBRAMANI

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

Dr.RAJESH.V



Medway

art beat counts

MEDWAY HOSP	<u>ITALS CARDIAC SURGIO</u>	AL CHECK LIST

	,
Name Mr. Balasubranani.	Age 62/H UHID MHI 2023
Diagnosis Unetable arrive / TYD	Plan CARG
Normal W function	
Serology Negative	N
	7. Theography Goosprin & Tel
EURO Score / STS Score のづり	PRE OP DRUGS (ACE/ARB/ANTIPLATELETS):
20 Y Y . *Diabetes Mellitus (HB1AC) //・ ナ/・	PRE OP DRUGS (ACE/ARB/ANTIPLATELETS): Shopped on 23/11 Associated Illness 7 20H / SHOW
Carotid Doppler Do holy	73. 15° 75 11.0 Thyroid Enzymes 751+ 1.11
Sr. Creatinine D. 40	Any other illness of concern
INR. 0.9	
Allen's Test	Myocardial viability if needed
Varicose Veins	
Pulmonologist Clearance	Nephro Clearance:
Neurology Clearance : -	Dental Clearance:
Mitral Regurgitation Assessment Trivial	MR / NO PAH
Nursing:	Billing Clearance:
Physiotherapy	Spirometry taught
Concerns from Surgical Team :	•

SIGNATURE: Parly (NHIO217)

Mr. Balesubranari Gr/M a befolo 720M, SHTN, Stp PTCA + Start , Distal & Proxinal CCX (2019) ,. Unitable aryina, no, Good LV has come for CABA. Pf. was doing well with needications toll I month apo when he durlpid street pain - retrasternol, Rediating to left shoulder associated will palpitations the breathteuners on exertion. Ho hilotecal leg association of the breathteuners on exertion. ewelling (+). Initally, he went to climas pout trust when he was advised ear and was referred to HHT He come to M42 on 16/12/2023 and underwent CAG which showed TVD. He was advised early carry,

ECA: 826pH, Since shytem, LYH (+).

COCR: Pafilus Luy fielde clear.

A Section of the second







(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.BALASUBRAMANI 62/Malc/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V

writing.

118 18 290 184 014 **11** 11 11 11 11 11 11 12 11 11 11 11 11 11

CONSENT FOR SURGERY

1.	Mr./Ms./Mrs BALASURRAMANI
tic	k correct option and below):
	Kead
	//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 diseaseCARANIRHARTERHDISEASE./JRIPLENESELDISEASE/DISEASE./DISEASE./DISEASE
	procedureC๒๑๑.พ.ж.ส ๕๕๕๔๘ ๒๔๒๖๑๓
•	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.
•	ا 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

- 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
 and paramedical team and that the doctor may seek consultation / assistance from relevant specialists if the
 need grises.
- 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.

 Possible risks & complications	Bleeding 2. Infectio	x 3- Shoke	4 Arrythmin
5. Palonged 100 stay	6. Hild nick to	ls fo	·
· Benefits Symptom fee	survisel.		
• Alternatives Not Available			
 The likelihood of success of the surgery 	(Percentage / Other commands)	१६७.	
 Possible results of non-treatment 	1. Myocardial Infanti		
	2. Heart Failure.	•	

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)	N. Balasubramani	B. PHJESWAPE				
Relationship	SELF	DAUGHTER				
Signature	Men	B. Ray				
Date & Time	27/12/23 at 17-00	97 pb3 @ 77.00				
Name & Signature of Doctor with Registration No.:						

11 22 36

Dr. V. RAJESH RASESH M.S. M.Ch(CTVS)

Senior Consultant
Cardiothoracic and Vascular Surgery
Reg No: 62794

Doctor Seal







நோயானி விவரங்கள்:(Affix Label here)					
សម្រាក់ :					
UHID :					
விறந்த தேதீ :	பாலினம் :				

<u>அறுவை சிகிச்சை ஒப்புதல் படிவம்</u>

நான்	நோயாளி அல்லது நோயாளியின்	ர பிரதிநிதி தயவுசெய்து மே	லையும் கீழேயும் (பாருத்தமானதை
தர்வு செய்யவும்				
படியுங்கள்				
🦳 எனது / என் நோயாளியின் தற்	போதைய மருத்துவ நிலை குறித்து விளக்	கப்பட்டுள்ளேன்.		
ூந்த ஒப்புதல் படிவம் ஆங்கிலத்தில் வி	ிளக்கப்பட்டுள்ளது. இந்த ஒப்புதல் படிவத்	தில் கொடுக்கப்பட்ட சிகிச்வ	சையின் செயல்பா	ட்டின் முழுப்பெயர்
)சயல்முறை பற்றிய தகவல்களை நா ல்	ள் முழுமையாகப் புரிந்து கொண்டேன்.			

• நோக்கம் கொண்ட நன்மைகள், சாத்தியமான அபாயங்கள் மற்றும் சிக்கல்களைப் பற்றி நான் இப்போது அறிவேன். மேலும் அந்த செயல்பாடு / நடைமுறைக்கு மாற்றுகளை கிடைக்கச் செய்கிறேன். எந்தவொரு செயல்பாட்டின் / நடைமுறையின் முடிவுகளும் நோயாளியிலிருந்து நோயாளிக்கு மாறுபடும் என்பதையும் நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையின் வெற்றி குறித்து எந்த உத்தரவாதமும் எனக்கு செய்யப்படவில்லை என்று நான் அறிவிக்கிறேன். பெரும்பாலான நோயாளிகளுக்கு சீரற்ற செயல்பாடு மற்றும் மீட்பு இருக்கும்போது சில வழக்குகள் சிக்கல்களுடன் தொடர்பு படுத்தப்படலாம் என்பதை நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையுடன் தொடர்புடைய பொதுவான அபாயங்கள் மற்றும் சிக்கல்களை நான் அறிவேன். இந்த செயல்பாடு / நடைமுறையுடன் சாத்தியமான அனைத்து அபாயங்களையும் சிக்கல்களையும் பட்டியலிட முடியாது என்பதை புரிந்து கொள்கிறேன்.

நோயாளியின் மருத்துவ நிலை மோசமாக இருந்தால் அல்லது எதிர்பாராத எந்தவொரு தொழில்நுட்ப காரணத்தினாலும் சில நேரங்களில் திட்டமிடப்பட்ட செயல்பாடு / நடைமுறைகளை ஒத்திவைக்க அல்லது ரத்து செய்ய வேண்டும் என்பதையும் நான் புரிந்து கொள்கிறேன். எனது சொந்த ஆபத்து மற்றும் விளைவுகளில் எந்த நேரத்திலும் எனது ஒப்புதலை நான் திரும்பப் பெறுதலை எழுத்துப்பூர்வமாக 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 சிகிச்சை / நடைமுறையின் போது மருத்துவர் மற்றும் துணை மருத்துவக் குழுவால் உதவப்படுவார் என்பதையும், தேவை
 ஏற்பட்டால் தொடர்புடைய நிபுணர்களிடமிருந்து மருத்துவர் ஆலோசனை / உதவியை நாடுலாம் என்பதையும் நான் இப்போது
 அறிவேன்.

•	சாத்தியமான அபாயங்கள் மற்றும் எ	சிக்கல்கள்	

	-		
_			
•	நன்மைகள்		
•	மாற்றுவழிகள்		
•	அறுவை சிகிச்சையின் வெற்றி வாட	ப்ப்பு (சதவீதம் / பிற கட்டளைகள்)	
		·	
•	சிகீச்சையின்றி சாத்தியமான முடிவ	கள்	
•	ടെയല്ലെ / ക്രൂപ്രത്ത വന്നൾ	വുന്ദ്യക്സ്വ. രോൽഡു ക്കാങ്ങില്ലക്കല് വിനക ഒകി	ர்பார்க்கப்படு ம் போக்கை யும் நான் அறிவேன். சில
			ம் அனுமதிக்கப்படும் கால அளவு தேவைப்படலாம்
	•	எள் அல்லது சிகிச்சைகளின் தேவை இருக்கலாம்	
•			ர முறையில் எனது உடலில் இருந்து அகற்றக்கூடிய
	• •		ளிக்கீறேன். இந்த ஒப்புதல் வடிவத்தில் வழங்கப்பப்
	. , , ,		று அறிவிக்கீறேன். எனது வியாதி, செயல்பாடு
			தன் அபாயங்கள், விளைவுகள், சிக்கல்கள் மற்றும் கட்டாசில சிக்கப்பட்டு வில்லை இக்க வேலக்கில் காரி
	•		ம் பதிலளிக்கப்படவில்லை. இந்த வடிவத்தில் நான் வண்டிய அனைத்து துறைகளும் (இந்த வடிவத்தில்
	நிரப்பப்பட்டன என்று நான் மேலும் க		_{පාහො} රුය ට හෙගෙනිම්
Γ			
L	விபரங்கள் 	நோயாளி / உறவினர் 	சாட்சியம்
l	பெயர்		
ľ	உறவுமுறை		
ŀ			
L	கையொப்பம் 		
	நாள் & நேரம்		
ľ	மருத்துவரின் பெயர் மற்றும் பத்	വ ദൽ. കെല്യെസ്ല്ല്:	
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ANAESTHESIA RECORD



(A Unit of United Alliance Healthcare Pvt Ltd)		Every heart beat counts
Patient Mr.BALASUBRAMANI Name: 62/Malc/MHI202381326 UHID: 27/12/2023/IPH2023002613 DOB: Dr.RAJESH.V DOA: Consul. ASA Grade:	a +w.	Day Care Delective Demergency Height: 158 cm's Weight: 78 Kgs Desis: Design HT, 15 65 // Anaesthetic Plan BA
History of Present Illness: ANGINA PTCA+STENT DYSPNOEA SYNCOPE MI CCF OTHERS Previous Surgery:	9)	HOL Ecoporón.
Physical Examination: JAUNDICE PEDEL OEDEMA CYANOSIS CAROTID BRUIT CLUBBING	SYSTEMC EXAMINATIO CVS: S157 RS: clean lung of	CNS: WNL,
HR: 82 mt NIBP:	SP02	
HB : 14 0 T.BILIRUBIN : 0, 43 PLAT : 3, 49, 600 I.D. : 0, 3 TC : 7, 180 0 1/2	7 T4 : 11.0 Urine:	ECG NSR. LNIT
CREAT: 0180 T-PROTEINS : 711	- TSH : \\\\-\\\-\\\\\\\\\\\\\\\\\\\\\\\\\\\	CXR WWL
K+ : 4,43 PTT/INR :1),5		TAGS TO MOR , Concentric LNH
Teeth Norsal Mallampatti class T	AROTID DOPPLER Monal Pil, carolid f otrood Doppler whidy	No RWMA Aosta Valve Edensin
Neck Movement WNL	·	Other Opinions:
TM Distance Wやレー	NPO From: 12 arid right	-
Pre Medication: Tab, Albone	O. Soof of tab. Parton	BI 18 #
Night Before Surgery:	ا من العرب ا	Blood Reservation PCV : のみ′ Platelet :
Day of Surgery Day, Many	In Stop + only 12 to 1 F.	FFP : CRYO :
		Whole Blood:
Remarks: Took and 2,500		-
	Dr. A. SAMUEL SYLVESTER	
esthetist Name with Reg.No. :	Reg. No: 43570	Signature: June

PRISONAL COMPRESSION POR SERVICE AND SECURITY CONTRIBUTED TO SECURITY CONTRIBU	D:	Anaesthetist	DR.JE	EVA-) PRAVE	FA)	Surgeo	n (DR) f	RAJESH			Anaesth ☑GA ☑F	ésia Tect Regional [ากเ๋que ⊒Others
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Sign	Sig	n-in Completed. L	aYes⊟i AANA.	₩ 1 □ ∨ 1	\ <u></u>	_				Mode of Vent	ilation: 🔲 Spont	taneous 🔽	ontrolled
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PATIENT SAFETY Position on Table:		T	Applicable	ZX. JE		_	_						·•
Position on Table:	- "		CAFETY	7		– ,	_					_	
Complication: Yes Yes Xim	Box					CVC Type	: <u>4 LUMB</u>	ZUSite: RT	<u> </u>			Removed	
Eye Care:	Pre	ssure points checke	ed & Pado	ded: 7 Ye	SUINU I			,	idance				
Varring Blanket: Yes No	Eye	Care: ☑/Yes ☐ No)					s No		LMA Type &	Size:	🗆	
Fluid Warmer: Yes No No No No No No No N						If Yes, det	iails:	7E 48 mg	<u>N</u>		omy ∐Face M	ask L_I Nas	al Prongs
TED Stockings: Yes Mo Sequential Compression / Decompression: PVC Type: Site: PVC Type: Site: PVC Type: Site: PVC Type: PVC Ty		_	, -								e / Time		
Sequential Compression / Decompression:							•			DUT. CEFUA	ROXIME 1	592Va	£9.30
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MORPHINE		MIDAZOLAM TYY			2/								
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BY UCW	3372	2_	/ D	r. J	EEVANA	NDAM. 722.8:01. ge	Ξ,	an	•		
ANAESTHE	SIOLOG	IST N	AME : L		.e g. 190: 83 	99 No: 8372:	Я	SIGNATURI	E		
REG.NO.			,								

POST OPERATIVE PLAN						
Transfer to: SICU Others, specify:						
Arrival in Recovery / ICU Time: 13 -35 SpO ₂ : 105 % HR: 45 beats/min Rhythm: SINUC RR: 14 breaths/min ABP: 151 73 mmHg CVP: 4 mmHg PAP:mmHg C.O:L/min Conscious state: AUNICE						
VENTILATOR SETTINGS:		IONOTROP				
SON of Wash	<-6 litres	- N.	/L-			
			The same			
POST OP ORDERS:						
-> to to A	IBG, ACT, CBG, CX	R				
_	DXYGEN THERAPY THE		THOR.			
MODIFIED ALDRETE'S SCO	RE (Score against each criteria)		1			
CRITERIA Activity, able to move, voluntarily or on command	PARAMETER 4 extremities 2 extremities		Scale 2 1 Total Sco	are ·		
Breathing .	Able to breath deeply and condition or limited Apnea		2) 1/ Patient fit	for discharge:		
Consciousnesss	Apnea 0 DYES NO Fully awake 2 1 Arousable on calling 1 unresponsive 0					
Circulation (Blood Pressure)	+20% of pre-anaesthesia level					
SPO ₂	Maintains SPO ₂ >92% in amb Maintains SPO ₂ > 90P% with Maintains SPO ₂ <90% with O	O ₂	1 0			
Anaesthetist Name & Reg.	Dr. JEEVANAN Reg No: 8372	11] / Signature			





OPERATION NOTES

)	Pre-Operative Diagnote Post-Operative Diagroup Operation Procedure	nosis:-do-		v4	Mr.BALASUBRAMANI 62/Malc/MHI202381326 27/12/2023/IPH2023002613 Dr.RAJESH.V	_
	D.O. Operation ವಿ ဥ	LMA→LAG LRA→ D.RU) SVG+07 A ¬		k the type of procedure : ♪ Open □	
	Operation IO: 4	(I)	Operation Completed :	ts:10	Nature of 46A Anaesthetic:	
	Surgeons De Rajie	h PA: så		Perfusionis	st -	
	Anaesthetist De. Zee			Nurse Ms.	. Radhika Ns. Devi	
	Incision Median a	temotomy				
	Cannulation		Arterial		Venous	
	Oxygenator			•	eva harveted. Le	•
	Total ACC T		nastomoeis LRA	done. -> D. RCA	myocardial etalih	'} ZQ\$,
	Findings and Relevar	<u>ıt Details :</u>		1-> 0M A-> LAD		
Gie	ood myp. conhactio at laden heart	<i>na</i> Puovan	-	-	geoft 8 LRA don	l onto

austa (Amm Runch). Protomonised. Hernodain secured.

Routine Crest closure done & dearn tules

Dr. V. RAJESH

M.S., M.Ch(CTVS)
Senior Consultant
Controller of and Mashaur Sungary
Controller of an Assault Sungary
Controller of an Assault Sungary

Insitu

Om - 15mm Healty at the clieval text

LIMA, LRA, SVG ? healthy (17-log) | Corduit

LAD-1.75m Proximally diseased Healthy at the side

Con. LUH.

POST-BY	PASS HAEMODY	NAMICS				•	,
F	AS		LA			, Cardiaċ Output	, '-
F	₹V		LA			C1	-
	svs			SYS			
F	PA	MEAN	ВР		MEAN		
	DIAS			DIAS			
F	PACW						
Support:	Isoprin Dopamine Dobutrex		Adrenaline I A B P Others				
POST-OF	PERATIVE INSTRU	JCTIONS :					
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	Chest Pleual Mediastinal Pericardial 2 Others	-	Vajed	,,,,			
Sponge C	ount: Courect.	، د الدعال	Dr. V. RAJES M.S. M.Ch(CTV: Senior Consulta	6 H S) .nt			
Surgeon :	Dr. Rajie		horacic and Vascu Reg No: 6279	iar Surgery 1		Date :2 <u>8</u> /ເລ/2.	3







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

NAME: Mr. BALASUBRAMANI	AGE/GENDER: 62 Years / MALE
UHID NO : MHI202381326	IP NO: IPH2023002613
DOA: 27/12/2023	DOS:28/12/2023
SURGEON: DR. RAJESH	ANESTHETIST: DR. JEEVANANDHAM/DR. PRAVEEN
ASSISTED BY: MS. SAIKUMARI	SCRUB NURSE: MR. SASIKUMAR/MS. DEVIKALA

DIAGNOSIS:

TRIPLE VESSEL CORONARY ARTERY DISEASE

S/P PTCA AND STENT TO DISTAL AND PROXIMAL LCX (10/08/2019)

ACUTE CORONARY SYNDROME

NORMAL LEFT VENTRICULAR FUNCTION

TYPE II DIABETES MELLITUS

SYSTEMIC HYPERTENSION

UNSTABLE ANGINA

SURGERY DONE:

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

LIMA TO LAD

LRA TO DISTAL RCA

SVG TO DISTAL OM1

FINDINGS:

Good myocardial contractions

Hypertrophic left ventricle

Fat laden heart

LIMA – 1.75mm, Good quality, good flow

LRA – 1.75mm, from left hand, good quality

SVG – 4mm, from left leg, Good quality

LAD – 1.75mm,proximal / mid LAD diseased, anastomosis site healthy #9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel : 044 - 4310 8959

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

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Medway Group of Hospitals Medway Centre of Excellence (Chennai) Kakinada **Heart Institute** Institute of Pulmonology Chengalpattu Villupuram Kumbakonam 044-2473 4455 | 044-26530011 | 044-27426829 | 04146-242000 | 044-2473 4455 | 0884-2333367 044 - 4310 8959 044-2473 4451



Heart Institute

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

DISTAL OM- 1.8mm, diseased vessel

DISTAL RCA - 1.75mm, thick walled vessel

Good distal run off in all the grafts

PROCEDURE:

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

Heart positioned and stabilized with myocardial stabilizer for DISTAL OM grafting. Arteriotomy was made and 1.5mm intracoronary shunt was inserted. The end of the saphenous vein was anastomosed to the side of the DISTAL OM artery with 7-0 prolene suture. (SVG TO DISTAL 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 Insitu 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 DISTAL RCAgrafting. Arteriotomy was made and 1.75mm intracoronary shunt was inserted. The end of the left Radial artery was anastomosed to the side of the DISTAL RCA artery with 7-0 prolene suture. (LRA TO DISTAL RCA)

Aorta occluded partially. Two 4mm holeswere made on the aorta with aortic punch. Proximal anastomosis of artery and vein grafts done onto aorta with 6-0 and 7-0 prolene suture. Protamine administered. Hemostasis secured. Pericardiumreapproximated partially. Routine chest closure done with one mediastinal and one left pleural tubes insitu

SUPPORTS:

Hewas shifted to ICU with nil support.

CONSULTANT SIGNATURE Dr. V. Rajesh, MS, M.Ch (CTVS)

Senior Consultant Cardiothoracic and Vascular Surgery

Dr. V. RAJESH Reg No : 62794

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

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Medway Centre of Excellence (Chennai)





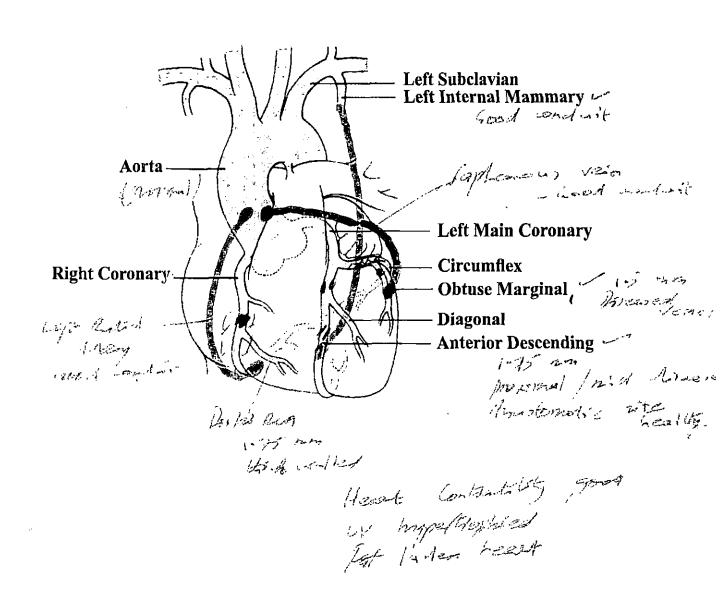
#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel: 044 - 4310 8959

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Type to Asserted Applement Approversion.



Name Mr. Brughas	BARAGE 62	/12 Ar /Date of Surgery	2 <i>§ 141-013</i> UHID.	No. 1919 20238152
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PATIENT'S INFORMATION SHEET

NAN 62/Male/MHi202381326	AMANIAGE/SEX 62/m:	UHID NO 20238139
27/12/2023/IPH2023002613	SURGEON	ANAESTHETIST
Dr.RAJESH.V	Dr. RAJESH	Dr. SYLVESTER
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DIAGNOSIS (In Capital Letters)	I. " CAD CTUDOS	[10] T
	2. " 72 Dm / HTN"	W. A · · · · · · · · ·
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PRESENT PROCEDURE/ SURGERY	CABAL GA.	(3/2, 7)
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PREVIOUS PROCEDURE/	HO RICA Stent	Distal & Proximal
1000		•
CONTACT NO. & CRELATIONSHIP	1. MEROTESTWAR) 2002:	•

MEDICATION HISTORY

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	1/8/23	7.7: cagrelor	gong	Ph	Hoj	23/12
2	3	T. Ecosprin	75mg	n	010	7
3	27	T. Telma	fores	ኣ	0-01	n
4	1/8/23	T. Angiplat	2004	9	1	٧
5	۲۰	T. Dyter plus	5/50mg	ץ	100 7	
6	3	T. Atorvay	Dong	୬	001 4	
7	'n	T. Methyl Cobaln	un Boom	_3	0-01	
8	۶	T. GOBEN	Zoons	n	041	continue
9	118/23	T Neurobion of	mto Har	. 1	00	
10	١,,	1. Bonit	Smy	ı	6-0]	
_11.	1/8/23	T. Niko Yan	بيشك	Ρ/2	<u> </u>	r———
S.No	STARTED ON	CURRENT MEDICATION (After Admission)		Route	Frequency	STOPPED ON
1	1/8/23.	T-Angisplat	2.50	9/0	101	
2	Ь	1. Dy by plus	5)50mg	Pb	100	7
3	n	1. Add vas	20mg	Ph	0-01	
4	n	7. methylcobalm	in Soony	pp	and	
5	3 1	T. GOBEN			011	
6	118 23	1. neurobionfor	e Itab	10	0-01	continue
7	2,	Tidsonit	Shig	Pb	0-01	
8		T. Cgnet som			to	
9	5	1. Janunet			010	
					ı f	1

ANY RELEVANT INFORMATION:

Admission / OT Receival Date and Time :	Condition of the Patient: 1. Stable / Unstable 2. Oriented / Disoriente 3. Conscious / Semiconscious / Unconscious				
From: To:	4. Febrile / A febrile		5. Intubated / Extubated		
Transfer Out	Condition of the Patie				
Date and Time :	1. Stable / Unstable		2. Oriented / Disoriented		
	3. Conscious / Semice	onscious / Unconscious			
From: To:	4. Febrile / A febrile	1000	5. Intubated / Extubated		
Transfer In	Condition of the Patio	ent:			
Date and Time :	1. Stable / Unstable		2. Oriented / Disoriented		
	3. Conscious / Semice	onscious / Unconscious			
From: To:	4. Febrile / A febrile	. 	5. Intubated / Extubated		
1) Known Case of	Year	Months	Days		
Diabetic Mellitus 2) Known Case of	20yn				
Hypertension		6 month			
3) Known Case of Bronchial Asthma/COPD		-			
4) Known Case Of Others					
5	☐ Yes	No No	1		
Denture	Permanent Fixatio	on			
	Temporary Fixation	on: Present / Absent			
	☐ Yes	No			
Allergic Reaction : Drugs/Food	If you means mention about Drug / Food Name:				
		. 57			
Pressure Ulcer Present	If you means mention a	No No about Grade: 1/2/3/	4 & Site:		

ANY RELEVANT INFORMATION:

		•		_	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: Inser	ted Date and T	ime :	Removed on	
	2. Pleural Right / Let	ft: Inserted Da	ite and Time	Removed on	
Urinary Catheterization	Inserted Date and Tim	ne	Removed or	 1	
Nasal / Oral Gastric Tube	Inserted Date and Tim	ie	Removed or	1	
Intubation Date and Time	Extubation Date And	Гime	Reintubatio	n Date And Time	
Other Information	10 bon 34115157	B Cood	Rosen	ration done Lavaryor	Que







Medway Hospitals The way to better health (A Unit of United Alliance Healthcare Pyt Ltd) **PATIENT'S INFORMATION SHEET** Mr.BALASUBRAMANI

62/Malc/MHI202381326	ACE / SEV	THIID NO.
NAME ^{27/12/2023} /IPH2023002613 — Dr.RAJESH.V	AGE / SEX	UHID NO
THE PROPERTY OF THE PART OF TH	SURGEON	ANAESTHETIST
DR. PASESH	DT. AMBARASU	DR. SEGVANDAM
DIAGNOSIS (In Capital Letters)	1. CAD - TVD	
	2. CONCENTRIC LY	H· ·
	3. HORMAL LY SYST	OLIC FUNCTION!
	4. GRAPE I - DIASTOLI	c pysifulction.
	5. ADRTIC: VALVE	"ICLERUSIS.
	6. TRIVIAL AR, TA	RIVIAL M.R.
10 . 1 . 1	7. CP- 65%	ing die diere
	8	124 35° 35° 35° 35° 35° 35° 35° 35° 35° 35°
PRESENT PROCEDURE/ SURGERY	OPCAB X 3 GRAPA LINA 7 LAG LRA> D	
PREVIOUS PROCEDURE/ , SURGERY	HO CAY (16 12 23)	DISTIBLE PROXIMOR LCX (2019)
CONTACT NO. & RELATIONSHIP	1.9941476652 V.C. [Mrs. Dejemani] dan	12. 9884460302 Velf.
N.No:- 37/577		THOURA

MEDICATION HISTORY

		MEDICA	IION H	1510K1		. : -
S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	1.8.23	TANGUISPLAT	Q-5 mg	P/D	1-0-17	
2	1.8.73	T. DYTOR PLUS	5/50mg	1/0	1-0-0 /	
3	1.8.23	T. ATORVAS	20mg	1/0	0-0-1	
4	1.8.23.	T. METHYL COBA CAME	soomg	Plo	0-0-1	
5	1.8.13	J-GOBEN	800 mg	P/0	0-1-/	Port qua
6	1.8.13	THEUROBIOIS FOATE	ITAG	P/D	0-04.	
7	(-8-13	T. ISOHIT	Sing	P[D	0-0-1	
8	1.8.13	T. CYMCT	soomg	Plo	1-0-1	
9	1-8.23	T. Janumet	50/50%	1. 19/0	0-1-0	
10	1.8.13					
	MATPLATE	EB STOPPED ON	23/12/	23		
S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1	29/12/23	TAB. FRUCEMIDE	Homby	Plo	1-1-07	
2	20/12/23	TAB . SPIRMOLATION	11m26	Plo	1-1-0	<u> </u>
3	'	THR - REPLEM FIXTE		Plo	1-0-0	}
4	1	THE CLOPILET HAPIRM			0-1-0	
5	1	TAB. ATORUDATHIN	1		0-0-1	
6		TAB. PAPA			1-1-1	Continue
7		NEB. LEVOLIN		•	Qu Kthey	
8	l	Syp. SUCRALFATE			1-1-1	
9	مراء المام	U TONG A SERVE	5	ν).	, , ,	

Boma

TAB. RETALOC 12-5mg

9

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ANY RELEVANT INFORMATION:

Admission / OT Receival	Condition of the Pation	ent:				
Nallelas	1. Stable / Unstable		2. Oriented / Disoriented			
Date and Time: 08/12/03	3. Conscious / Semiconscious / Unconscious					
From: To: SICU	4. Febrile / A febrile		5. Intubated / Extubated			
Transfer Out	Condition of the Patie	ent:				
Date and Time: 30 12 23	1. Stable / Unstable		2. Oriented / Disoriented			
at 12:00	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			
2	3. Conscious / Semice	onscious / Unconscious	ĺ			
From: To:	4. Febrile / A febrile		5. Intubated / Extubated			
1) Known Case of	Year	Months	Days			
Diabetic Mellitus 2) Known Case of .	20 Year					
Hypertension	-					
3) Known Case of Bronchial Asthma/COPD						
4) Known Case Of Others	BYSL MIDEMIA					
Denture	☐ Yes ☐ Permanent Fixation ☐ Temporary Fixation	No n n: Present / Absent				
Allergic Reaction : Drugs/Food	☐ Yes ☐ No If you means mention about Drug / Food Name:					
Pressure Ulcer Present	Yes If you means mention a	No Shout Grade: 1/2/3/	4 & Site:			

ANY RELEVANT INFORMATION:

	<u> </u>			_			
					Sign With Date		
Peripheral Cannulation	1. Site: RT CUBITAL	1. Inserted Da		1. Removed on:	Non 527 221121		
	2. Site:	2. Inserted Da	te and Time	2. Removed on:	27112		
	3. Site:	3. Inserted Da	te and Time	3. Removed on :			
Neek Line: IJL/EJL	Site:	Inserted Date		Removed on 30 12 28 at 10.5	Janes -		
Arterial Line: Right/Left	Site: RI RADIAL	Inserted Date	and Time	Removed on	Ship		
Sheath Arterial / Venous:	Site:	Inserted Date		Removed on			
Pressure Bandage	Site:	Inserted Date	and Time	Removed on			
Drain Site	1. Mediastinal : Inser	Removed on 39 12 63 CO 9.30 Removed on	CARLIE TOTA				
Urinary Catheterization	Inserted Date and Tin	ne 9-30	Removed on	ST ST ST ST ST ST ST ST ST ST ST ST ST S			
Nasal / Oral Gastric Tube	Inserted Date and Tin	ne .	Removed or				
Intubation Date and Time	Extubation Date And	Time	Reintubatio	n Date And Time			
Other Information	CHEST PAH & A CAY. ON 1 SCREELING CAROTID A 19-12-23	patient came with complaints of chest part & Breathless Ness care on 16.12.2023 Screenling echo on 19.12.2023 CAROTID AND VERTE-BRAL DOPPLER ON 19.12.23 FCG BONE ON 19/12/23 [HR- 826pm]					



Mr.BALASUBRAMAN1
62/Malc/MHI202381326
27/12/2023/IPH2023002613
Dr.RAJESH.V



CONSENT FOR BLOOD / BLOOD COMPONENTS

A Blood transfusion	is life savi	ng medical	procedure,	prescribed	by a physic	ian. Blo	od can	be given	'whole'	but
more often a compon	ent or comb	ination of	component	is transfused	l. Among th	e most co	ommon	compone	nts 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. N. BALASUBRAMANT
Witness Witness	Patient signature brain
Doctor . Juylung Time 13,00	or Guardians name B RAJESCOARR
Time	Guardians signature R. Pay
Date	Relationship to patient. Daughtu.
. 1	threatening/emergency medical condition. I have provided the
patient information sufficient to be considered info	ormed consent and I have proceeded with ordering blood products
to be administered in sufficient quantity to alter, in	nproved or reverse a life-threatening/emergent medical condition.
Time: 13.00 Date: 28/12/23	Doctors signature





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ஒப்புதல்:இரத்தம் / இரத்தத்தின் பாகங்களை செலுத்துதல்

இரத்தம்	சேலுத்த	_ச தல் என்பத	து, மருத்துவரா	ல் பரிந்துமை	ரக்கப்படுகி <u>ன</u> ்	ற ஒர் உயி	ர் காக்குப்	மருத்துவ	செயல்முவ	றையாகும்.	, ശ്രത്യമനമ്പങ	இரத்தம்
அளிக்க	ப்படலாம்	என்றாலும்.	பெரும்பாலும்	ஒரு பாகம்	அல்லது ப	ரகங்களின் <i>(</i>	හෙනෙ ඛ ම	சலுத்தப்படு	கிறது. மிக	ப் பொதுவ	வான பாகங்களி	ல் ்
கீற்க்கன	in econ o	ALJŠKASLŪ:										

சிவப்பு அணுக்கள்

இரத்தப்போக்கு அல்லது குறைந்த ஹீமோகுளோபினுக்கு

தட்டணுக்கள்

இரத்தப்போக்கு அல்லது குறைந்த எண்ணிக்கைக்கு

குருதிநீர்

இரத்த கனஅளவை மீட்டமைப்பதற்கு அல்லது உறைவு அம்சங்களை வழங்குவதற்கு

கிரையோப்தெஸிப்டேட்

சிறப்பு உறைவு அம்சங்களுக்காக

எனக்கு /நோயாளிகளுக்கு இரத்தம் செலுத்தப்படுவதன் மூலம் எதிர்பார்க்கப்படும் நன்மைகள் மட்டுமின்றி இடர்களையும் மருத்துவர் விளக்கியுள்ளார்:

- 1. இரத்தம் செலுத்துவதில் கிடைக்கின்ற விருப்பத்தோவு பற்றி எனக்கு தகவலளிக்கப்பட்டுள்ளது, இதில் தன்னாள் தாணமளிப்பவர்கள் வழங்கியுள்ள வங்கியிலுள்ள இரத்தம் (அலோஜெனிக்) அல்லது சுயமாக தானமளித்தல் (ஆட்டோலோகஸ்) ஆகியவை அடங்கும். ஒர் அவசரநிலையில், வங்கி இரத்தம்தான் பயன்படுத்தப்பட வேண்டியிருக்கும். நேரம் கிடைக்கும் பட்சத்தில் சுய தானமளிப்பிற்கு வாய்ப்புள்ளது.
- 2. தேசிய விதிமுறைகளுக்கேற்ப கவனத்தூன் முன்சோதனை செய்யப்பட்டிருந்தாலும், உயிருக்கு ஆயத்தை விளைவிக்கக்கூடிய தொற்றுக்களான எய்ட்ஸ், தெறுபடைடிஸ் 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, போரிப்பு, மூச்சுத்திண்றல், அதிர்ச்சி மற்றும் அரிதான நிகழ்வுகளில் இறப்பு ஆகியவற்றை உள்ளடக்கி, அந்த வரம்புக்குட்படாதவையாகவும்கட் இருக்கலாம் என்பதையும் நான் புரிந்து கொள்கிறேன்.
- 3. இரத்தம் செலுத்துவதன் மூலம் எதிர்பார்க்கப்படும் நன்மைகள், அதிர்ச்சி, முளை மற்றும் இது உறுப்புகளுக்கு ஏற்படும் சேதம் குறைக்கப்படுதல், குணமடைதலைத் தசிதப்படுத்துதல் மற்றும் இரத்தம் இழக்கப்படுவதைக் குறைத்தல் ஆகியவற்றை உள்ளடக்கியிருக்கலாம், என்றூலும், எதிர்பார்க்கப்படும் நன்மைகளுக்கு உத்தரவாதம் ஏதும் அளிக்கப்படவில்லை என்பதையும் நான் புரிந்து கொள்கிறேன்.
- 4. இரத்தம் செலுத்துதல், மாற்று சிகிச்சை முறைகள், சிகிச்சை எடுக்காமல் இருப்பதிலுள்ள அபாயங்கள், பயன்படுத்தப்படவிருக்கும் செயல்முறைகள், மற்றும் இதிலுள்ள இடர்கள் மற்றும் அபாயங்கள் ஆகியவை பற்றிய கேள்விகள் கேட்பதற்கு எனக்கு வாய்ப்பிருந்தது, மேலும் தகவலறிந்த நிலையில் முடிவெடுப்பதற்கு ஏற்ப எனக்கு போதிய விவரங்கள் தெரிந்திருந்தன என்று நான் நம்புகிறேன்.
- 5. முறையான மருத்துவப் பராமரிப்பின் பொருட்டு, இரத்தம் மற்றும் /அல்லது அதன் பாகங்கள் செலுத்தப்படுவதற்கு நான் ஒப்புக்கொள்வதுடன், எனது கையோப்பத்தின் மூலம் எனக்கு அல்லது நோயாளிகளுக்கு இரத்தப் பொருட்கள் செலுத்தப்படுவதற்கு என் ஒப்புதலை அளிக்கிறேன். இதே நோய் தொடர்பாக, இரத்தப் பொருட்கள் செலுத்தப்படுவதற்கான எதிர்காலத் தேவைக்கு வாய்ப்புள்ளது மற்றும் அது தொடர் அடிப்படையில் இருக்கலாம் என்று எனக்குத் தெரிவிக்கப்பட்டிருக்குமானால், இந்த மருத்துமைனை சேர்ப்பின் குறிப்பிட்ட காலத்தில் முடிவடையும் வகையில் அல்லது இந்நோயின் முழுமையான காலகட்டத்திற்கும் தேவையான கடுதல் இரத்தப் பொருட்கள் செலுத்தப்படுவதற்குரிய ஒப்புதலையும் இத்தகவலறித்த ஒப்புதல் மூலம் வழங்குவதற்கு நான் ஒப்புக்கொள்கிறேன்.

	நோயாளியின் பெயர்
சாட்சி	. நோயாளியின் கைபொப்பம்
மருத்துவர்	அல்லது பாதுகாவலரின் பெயர்
நேரம்	பாதுகாவலரின் கைபோப்பம்
தேதி	தோயாளியுடனான உறவு
உயிருக்கு ஆபத்தான/அவசரக்கால மருத்	துவ நிலை காரணமாகத் தகவலநிந்த ஒப்புதல் பெறப்படவில்லை. தகவலநிந்த ஒப்புதலாகக்
கருதப்படக்கூடிய அளவிற்கு நான் போதி	ப அளவு தகவலை நோயாளிக்கு வழங்கிவிட்டேன், மேலும் ஓர் உயிருக்கு ஆபத்தான/அவசரக்கால
மருத்துவ நிலையை மாற்றுவதற்கு, மேம்	படுத்துவதற்கு, நேர்மாறாக ஆக்குவதற்கான போதிய அளவில் இரத்தப் பொருட்களை வழங்குவதற்கான
உத்தரவை வழங்கும் நடவடிக்கையை நட	rண் மேற் கொண் டுள்ளேன்.
நேரம்:	•
நோயாளியின் பெயர்	மருத்துவரின் கைபொப்பம்
கே.வி.	





SAFE PROCEDURE CHECKLIST Adapted from WHO Safe Surgery Checklist



	Every heart beat	count
-	Mr.BALASUBRAMANI	

Name of the Procedure :	opcab [closed w	2-8 12 2023 @ 62/Malc/MHI202381326 27/12/2023/IPH2023002613			
Does the Procedure involve			8°CL .	13.30 Dr.RAJESH.V	
SIGN IN 9 220 Before Induction of Procedural S		TIME OUT 1020 After procedural Sedation and before procedure		SIGN OUT 118-30 When Doctor indicates that the Procedure is completed	
(Anaesthetist / Qualified Physicia Sedation + Nurse + Technician + Do	n administering Procedural ctor performing the procedure)	(Anaesthetist or Qualified Physician administering Procedural S performing the Procedure		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	Yes	Identity by two identifiers	Yes	Name of the Procedure done written down Yes OPCAB (CLUSED HEHZE)	
Procedure	☐Yes	Procedures	☐Yes	Name and site of all specimens / investigations ☐ Yes ☐ NA	
Side	□Rt FLt □NA CHEST, left, hourd	Side Expected Blood loss 300 - 400 ml	CHEST, CONTINUE	confirms labeling and sent to lab	
Consent		Position SupINE	ĒŢŶes	Any recovery concerns : ☐ Yes ☐ None	
Known Allergy	Yes Not known	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 Ing. lefture ma	59m@9:30	Any Equipment / instrument problem that needs to be	
		Venous Thromboembolism Prophylaxis Provided	☐Yes ☐ NA	addressed : ☐ Yes ☐ Nor If Yes, Pls. specify :	
All concerned anesthesia equipment	and medication check complete	Anticipated duration briefed	⊡Yes	sponge, cause, needle and	
Spo2 □MBP □Other	s pls. specify	Anticipated blood loss briefed	□Yes □NA	instrument Courts Correct	
Pre OP medication taken	☑Ýes □No	Adequate fluids and blood available	☑Yes □NA	instrument works 2/125	
1		Team briefed on any critical or unexpected steps	⊉ Yes	Corrective action :	
Required equipment for	☑Ýes □NA	For procedural sedation cases	☐ Yes ☑ None	N/W	
procedure available		Any patient specific concerns : Intra procedure glycernic control	Yes NA		
	Dr. V. RAJ	EApy doncerns about sterility	☐ Yes ☐ None		
Anaesthetist / Doctor giving Doctor performing that ant Nurse: PNS pai ware Technician: Back				ALRISHNI Nothers Please Specify: 1/c CHRISTINA	
γιοcedural Segation : Dx. γα	Sec No. 83	SUTATHE SUITATHE		0041 0036	
Date: 22/12/23 W	Reg No: 62 Date: 22 12 12 Time: 18.30	Date:	ate: 28 12/23 ime: 18.80	1 1 1	





Patient Deta<u>ils (Affix I</u> ahel here)

Name:

Mr.BALASUBRAMANI

UHID: Dob: 62/Male/MHI202381326 27/12/2023/IPH2023002613

DOA:

Dr.RAJESH.V

Consultant:



CONSENT FORM - PHYSIOTHERAPY

i, Mr. Balandraman the Patient or representative of patient have (please tick the correct option above and below):
Read TV (Mark bour bean symbol model to a symbol panelition of mark my nation)
If We have been explained the current clinical condition of me / my patient Been explained this consent form in TAML (Name of language) which I fully understand and understood
the information provided about Operation / procedure (warne or ranguage) which it hairy understand and understood
<u> </u>
Post operative Candiar Pulmonosy, Rehabilitation
(full name of operation / procedure given below in this consent form)
· •
Brief description of the Operation / Procedure: DBes, Sprandy, Edercise, Check Percussia
to Ble Cheet Wall, Aron to B/L VL LL, Mobilization
Lundonton data into adad ban ofita of undorgoing the gracedure. The intended banefits from this procedure are:
I understand the intended benefits of undergoing the procedure. The intended benefits from this procedure are:
10 Mysique Jourt Roy, 10 Mysique Ming Capacity of James
To Properous Jourt Roy, To Properous deurg Capacry & function
I understand that all procedures carry certain risks. The potential risks and complications from this procedure:
Paur
I have been explained the implications of not undergoing this procedure and the alternative methods of treatment like:
ney
I declare that I have received and fully understood the information provided in this consent form, that I have been
given an opportunity to ask questions relating to my ailment, the operation / procedure being performed, its risks,
consequences, alternatives, potential complications and intended benefits and recovery, and that all my questions
have been answered to my entire satisfaction and there are no misconceptions or false hopes in my mind. I further
declare that all fields (of this form) requiring insertion or completion were filled in my presence at the time of my signing this form.

Signature of Patient / Patient's Relative (only if Patient is unable to sign): For the above mentioned operation(s) / procedure(s) that I have been made aware of, I give my consent voluntarily to Dr. ARASH (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 1, the above named Patient / named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.						
	Signature / Thumb Impression*	Name	Date	Time		
Patient						
Surrogate/Guardian (if applicable #)	13hu/=	Bhuvaneswari (Write name and relationship with patient)	28/12/23	<i>[4:40</i>		
Reason for surrogate consent	Patient is unable to give consent because:					
Witness	Rapis	Vora FLORANCE .S	28/12/23	14:40		
Interpreter (if applicable)						
* Right Hand for Males & Left Hand for Females # Only if Patient is a minor or unable to give consent I, the undersigned doctor, have explained the nature, potential risks and complications, intended benefits, expected post-procedure course, and possible alternatives to the planned operation / procedure, to the patient / patient representative. I am confident that he / she has understood the information fully as described in this document.						
	·			, [

•	e/she has understood		•	 	in representativ	0.14
		ĭ				

Signature		Name '	Reg. No.	Date	Time
Consent obtained by	G. tolkal	ALLASH. G.E	0256	29/12/23	11pile
Procedure performed by	G.K. Akay	AKASH. G.E	0256	28/12/23	14:40



Patient Details (Affix Label here)

Name: UHID:

Mr.BALASUBRAMANI

DOB:

62/Malc/MHI202381326 27/12/2023/IPH2023002613

DOA: Consultant:

Dr.RAJESH.V





IN-PATIENT INITIAL ASSESSMENT FORM - PHYSIOTHERAPY

Chief Complaints:	tromal) Radiating to 10			
Chief Complaints: PT @lo Chest pour Pretvoet				
Shoulder Shoulder	palpstation C1 March)			
clo Breathleisnes	on execution			
Occupation: Heavy Activity Moderate Activity	Light Activity			
Past Medical / Surgical History:	1. 141- ozan stout Carral			
k/do DM x 20 yru	K1410 PTCA+ Stent (Dustel			
Kleb Houx smouth	Sperosmal Lex.			
klelo DMX 2044 Klelo HTVX bmonth Klelo Dyslipidenia.	K/Ho Rap-Appendicectory			
V	K/Hlo eAG (16/12/28)			
On Observation: Built: Thin Z Fair Well Built Obese Postural Deviation: Yes No Muscles Wasting: Yes No Deformity: Yes No Swelling: Yes No Gait Deviation: Yes No External Appliances: Yes No				
On Palpation:				
Tenderness: ☐ Yes ☐ No Warmth: ☐ Yes ☐ No Muscle spasm				
Oedema:□Yes ☑No │ Crepitus:□Yes ☑No │ Tone:□Normal □	Abnormal			
FALL RISK SCREENING NIL				
Fall Risk Screening for Adults: ☐ Age more than 65 years ☐ Hist	tory of fall in last 3 months			
☐ Walks with assistance ☐ Any	y neurological problem			
In case of 2 or more criteria is met, initiate detailed fall assessment a	and fall prevention protocol.			
Fall Risk Screening for Pediatrics: N↓ ☐ H/O fall in last 3 months ☐ Neurological problem (vertigo, seizure, etc) ☐ 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): NU				
☐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: NIL				
☐ Cervical ☐ Dorsal ☐ Lumbar ☐ Sacral ☐ Coccyx				
Associated Injuries: Speech impaired: Yes No				
Voluntary Movements: ☐ Present ☐ Absent Tone Modified: ☐ Hypotonic ☐ Normal ☐ Hypertonic				
ASHWORTH SCALE: NU.				
☐ Tightness ☐ Contracture ☐ Deformity ☐ Sensory Deficit				
Balance: ☐Good ☐Fair ☐Poor │ Co-ordination: ☐Good ☐Fair ☐Poor				
Functional Activities				
Self Care: ☐ Independent ☐ Dependent │ Bed Mobility: ☐ Independent ☐ Dependent				
Transfers: ☐Independent ☐ Dependent ☐ Ambulation: ☐Independent ☐ Dependent				
FIM Score:				
Breathlessness (If applicable):				
Dyspnoea Grading Scale: Grade I				
Abnormal Breathing Sounds: ☐Wheezing ☐Stridor ☐ Crackles ☐ Pleural Rub ☐ Pneumothorax Click ☐ Stertor				
Abnormal Breathing Pattern: Abdanihal breathing				
Pain Assessment: Pain: 🗆 Yes 🗆 No				
Pain Assessment: Pain: 🗵 Yes 🗌 No				
Pain Assessment: Pain:				
Pain Score: 6 10				
Pain Score: Pain Score: Pain Scale Visual Analog Scale Wong-Baker Faces Pain Scale Critical Care Pain Observation Tool FLACC				
Pain Score:				
Pain Score: Pain Score: Pain Scale Visual Analog Scale Wong-Baker Faces Pain Scale Critical Care Pain Observation Tool FLACC				
Pain Score: Die Tick whichever is applied: Numerical Rating Pain Scale Visual Analog Scale Wong-Baker Faces Pain Scale Critical Care Pain Observation Tool FLACC Location: Duration: Work Frequency: Character:				
Pain Score:				
Pain Score:				
Pain Score:				
Pain Score:				
Pain Score:				
Pain Score:				
Pain Score:				

Examination (Examination (Please tick and mention abnormal findings only):							
☐ Range of Motion:								
	Mormal							
	\							
☐ Muscle Stre	ength:		•					
	Normal							
☐ Reflexes:	Reflexes:							
Plantar Respo	nse: Diminished 🗆 Brisk	∢						
Biceps: □æin	∽ ninished □Brisk □Clonus	3	-					
Triceps: 🗹 Dir	_ minished □Brisk □Clonus	s						
Supinators:	☐Diminished ☐Brisk ☐Clo	onus	,					
Knee: □Dimi	nished Brisk DClonus							
Ankle: □Dimi	inished ☐Brisk ☐Clonus							
Sensation:	Sensation: Good,							
Investigation & Findings:								
	Unetable an	genal CAD-TND) TZ	DM SAM					
ı		0 ,	Dylspiden	شقر				
Physiotherapy	y Management Plan:							
	- DBOI	lan Quario	_		1			
	Sprouve	porcueià to Bh	duet wall)				
	Chlit	h _ l _ l _ l _ l _ l						
	- Arom	to BL ULAUL						
- Spisometry quecie to Bhe duet wall - cheet percuesión to Bhe duet wall - prom to Bhe Under - Mobili Zation								
	Signature	Name	Emp. No.	Date	Time			
Physiotherapist	G.E. Akay	AKASM. G.E	02.56	28/12/23	14:30			

	RE-ASSE	SSMENT FORM	
Date & Time 29/12/23 4 10:00	Fall Risk Score: - Pain Score: 3/10 Sugreal Site Parallel - Drew Con Sprometry - Just proces - Akom fo I - Mobile Zali - To Purpose - To Purpose - To Purpose - To Purpose	euroged so envouraged usin to ble chest wa Ble velle e Torot Rom ve dung vapacity lofu	
	Post Intervention Pain Score: 3 Treatment Care & Plan: four openation Signature	lo andia Relinguary Rehal	nl tation Emp. No.
Physiotherapist	G. F. Aleal	AKASH.G.E	०२६७





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Mr.BALASUBRAMANI

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

Dr.RAJESH.V

		PHYSIOTHERAPY TREATMENT CHART	
DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
28/12/23	17130	- PT ontable extribated	G. B. Albal MH10256
28/12/23	22:00	- DBey Eurouraged - Spirometry esi eurouraged - Ins:60000 - ARON esi to Ble UL ELL S B Ramanathan.P	MH1023:
		- DBE's encouraged - Chest percussion to Bh Chest wall - AROM G's to Ble UL 2 a - Spirometry G's encouraged - Eins: 600ce Exp: 600a	
29/12/23.	6:00	If R Ramanathan of - DBE's encouraged - Churt percuesion to 8/2 Check wall - AROM Er's to Ble UL 2-U - Spirometry Er's encouraged - This: 600cc Erp: boxce	ARP MH1 0260





Medway Hospitals®

The way to better health
PHYSIOTHERAPY TREATMENT CHART

MH/ PRINT / 0096 / PHY

Mr.BALASUBRAMANI

62/Male/MHJ202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
29/12/23	(0,100.	S/3 J-VI)AGARAGAVAN	
		D32 Culomyed	
		- client premutou due to she chept wall	
		- Active es to Ble U soll	ı
		- Sparonty end Enlaugel.	J ~~~~
		Fis-Good Br-Goode	Mmc-2loz
		- platet mobilised to chair.	
29/12/23	17:00	Sle AKASH	
		Det Euceuraged	G. B. Alad
i		- Sprometry est Eucowaged	MHOESG
		Ins: 600ce pap: 600ce	
		- Chest porcuesion to Ble Chest walf	
		- Aron to Bh ville	
		- pt chain Mobilized	
		- PT probabilized Preson the	
		lee	





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

Dr.RAJESH.V

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
29/12/23	<i>2</i> 2:00	S/B Ramarathan-1 -DBE'S encouraged - Chest percursion to B/c Chestual	John Jan
	5 5 5	- Apom Or's to Blive & u - Spisometry Or's encouraged In: 600 a Orp: 600 ce - Pt Chair Mobilishd.	m+110260
30/12/23	. 9100	SIB JUNAGARALIANAN DBR'S enlowingel	
		- Chest Peacondon to Ble Chest wall	
i i		- Sphromaly end enlanged The books Exposions - Active end to Ble U/ Sll	J. my
30/10/123	1-7100	- Patant mollisted to char. S/B AMBER - OBER EUROUNDAGED - Cheet proceeding to Ble Cheet wall	Gi B. Apoll M WH 10286
		- ARON FO BL VILL - Sprometry our sucouraged Tour beace Bape books - pt problemed	





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

Dr.RAJESH.V

PHYSIOTHERAPY TREATMENT CHART				
DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS	
31/12/23	(0;00	Sts John Arterian		
31/12/23	5 ~∞ ∂	Deed encounged - Chert pennson dans to Ble chert wall - Shrowely ear onlowed - Herbooce Ran booce - Achre en to Ble UL & U. - Pt wohlbel Slo J. vijayaranan	J. my MMC-2102	
01/01/204	10:00	- Chert paringer done to Ble chart was - Shiromety ear enbryed - Shiromety ear enbryed - And the color of the color of the - Other consumption - Shirometry and encouraged - Shirometry and encouraged - Deer percussion to Ble Cheet wall - Arom to Ble UL (CL - PT Stair Almh encourage	J. my mmc-2102 G. P. Akas M 1410256	





Mr.BALASUBRAMANI

62/Malc/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V

URINE

URINE ROUTINE ANALY	SIS <u>IVITUROBIOI</u>	LOGI SHEET	<u> </u>	TO BRITE HERO SITUATION OF THE PROPERTY OF THE
DATE	19/12/23			
COLOUR	PALE VELLO	7		
REACTION			[
SPECIFIC GRAVITY				
APPEARANCE	CLEAR.	_		
ALBUMIN				
SUGAR	(A)			
ACETONE	\ -			
BILE SALT				
BILE PIGMENT	·			
UROBILINOGEN				
PUS CELLS	3-5			
EPITHELIAL CELLS	1-C			
RBC	MIL			
CASTS	NIL			
CRYSTALS	2			
OTHERS	RIIL			
_				

MICROBIOLOGY-CULTURE REPORTS

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





Mr.BALASUBRAMANI

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

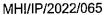
Dr.RAJESH.V

URINE ROUTINE ANALYSIS MICROBIOLOGY SHEET

1/2/23		1
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LIGHTLY TURBID		
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3-5		
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	3-5 1-2 NII NII	1-2 NII NII

MICROBIOLOGY-CULTURE REPORTS

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









Every heart beat counts

DIABETIC CHART

Mr.BALASUBRAMANI

62/Malc/MHI202381326

7. Cgmet 500 (7) f

T. Cgmet 500 (7) f

(A/F)

ACTUAL WE	EIGHT	HbA ₁ c	I.I	wet-	WOSULIN 32	/B/P)
PREVIOUS	DIABETIC N	MEDICATIONS		7	25 - TAMDHET 51	15-25
DATE	TIME	MEDICATIONSBy BLOOD SUGAR				
27/2/23	R36	301 mg/dl	#1. 	H 30/40 - 150 1A-80 TANUHET SO DO	13/12 03/16	Dr. praveen
					ļ '	,
	12.30	167 mg/dl	T. C.	Woerlin.	10 10 20 20 PM	1) or Power
28/12/23	, ,	167 mgldl 285mpldl.	314	gnet 50 00 <u>Woerlân</u> (30/70) 151 · HASU.	Dow .	2) Dr. Powers 2 Dos Just
					21	٢
		-				
			_			
			_			
	_		_			`

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.
		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.



PREVIOUS DIABETIC MEDICATIONS

ACTUAL WEIGHT





Every heart beat counts

T- DAPAVEL 10mg 1-0-0 (AP)
T-G2124TO 60 1-0-1 (BP) DIABETIC CHART

78.2/29 HbA,c.

T. JANUMET 5/500 1-0-1 (A+)

Mr.BALASUBRAMANI

62/Malc/MHI202381326 27/12/2023/teH2023002613

Dr.RAJESH.V

ANT WOSULIA

DATE	TIME	BLOOD SUGAR		DIAB	ETIC DRUG	Sign.	ENDORSED BY
03.17.77.	14.25	293 mg/al		AIV. IN	nan actrapid Estartio @14	arotoria osto	DR-PRAVEGI.
	18.30	198 mg (d)	_	INJ. HUH	AN ACTRAPAD	Mais post of	DY. Pravoou.
	22.00	Hanged.	•	#\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	man Action	10 Baton 100	Dr. pravean
09/12/23	N0.00	145mged)		-Elmi		1, contra	Sr. praveen
	194·30	266 mgloy.		Su ho	eman Hetrapi lui ginen	A Charles As A	DR. praveen.
	Ob. 30	227 mglol	,		70 Killing given a 161-1000 00	1. 1000 g	Dr. praucon.
		Ü		_	NA DO QU	mat 9.300	
20/12/23	13.30	293 mgdl	174	J. H.M	IUN JINGA L <u>XFIUN</u> Z	Claus (con	DY-PYNVOM.
	19-30.	254 mgld1		rannold Dag-Hw	25 20 20 25 25 20 20 20 20 20 20 20 20 20 20 20 20 20	Sw 340 V	DR-PPAVEEN
30/12/13	5.00	168 mg/dl		MONTO	of 7 to	Jan 10074	1 10
					vel long lind vet romanor is	PB given at 8.30	Dr. movou.
				14 . HUHB	N MIXTERD QU IV GIVON	et 9.00 dans	Dr. prakeu.
		INSTRUCTION	ONS FO	<u>DR INSI</u>	<u>JLIN INFUS</u>	IONS VIE	J. 1
		g insulin in 40 ml. of		SUGAR / dl		INSULIN INFUS	ION
		on 1-2 u / hr	< 100		if B.S. is still <1 B.S. every 30 r	or 30 mins, rechect 100 give Glucose a nins, until the level fusion with rate 1 u	nd recheck is above 150.
		cose hourly (every 2nd	150-2	00	Adjust Infusion	rate to 2u / hr.	
		e) and adjust Insulin rate Illowing Algorithm.	201-2		Adjust Infusion		
* Target P	Nood Suga	r 150-200 mgs.	251-3		Adjust Infusion		
_		_	301-3		Adjust Infusion		
	tor K+ sepa	arately.	351-40 >400	UU		rate to 10u / hr.	
Urine A	cetone		- 700		Aujust Illiusion	Tale to Zou / III.	



T-Dayawel long
Heart
Institute

DIABETIC CHART

Everu heart beat counts Mr.BALASUBRAMANI

p_i 62/Malc/MHJ202381326 **N**i 27/12/2023/IPH2023002613

UI Dr.RAJESH.V

ACTUAL WEIGHT T8.2Kg HbA,c 11.74.

PREVIOUS DIABETIC MEDICATIONS 25-25-25 U (8/P)

DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
30/12/23	12.30	269 metals	Ing. H. M 20 Wish	· 8000	Do lajesh
	1830	318 marlel	Zny HA 12U2	عن الإ	WILL STREET
			IN HM -250	Den kom Stars	10-1
			T- 7 anumot	BOTH O'S	7
31 1/2/23	6:30	186 mg [d]	J. Dapavel Ion		
		. 0	Thisado 80mg	YA	r-francen.
			T. Januared SO	200-1	
			In iztra (2	() \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Y _
	భ్తుత్త	348 mald	This wixtand	Jul 14. 2	K00121879.
-	18-30.	319 maldl	IN. HA - 100	CBP	W.
			1 · Crittatax	mar CBIE	245h
			T. Flanumo		

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 following ragerianis.	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.



T. paparel long 1-00 AP) MHI/IP/2022/065

T. JAMUMETGO SOON

∟Medway

Mr.BALASUBRAMANI

62/Malc/MHI202381326

27/12/2023/IPH2023002613

Dr.RAJESH.V

AAN IPN THAT AND BED A DISTURBATION OF THE CO.

				110 Jan 1811 I H H H B B H H B H H H H H H H H H H H	
ACTUAL WI	EIGHT	78 2 Kg HbA,c.	U.F.Y. IN	J. WOSUH -25-25	N 30170 (B/F)
PREVIOUS	DIABETIC N	MEDICATIONS	25	- 2h - 25	
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
111/24	6:30	180mg dL	T. Wiredo MED	4 @ F1 80	mdr. Beneen
			T- Janumet Jobs	give at	
			fy. Hm agu	24	
	12.30	205 mg/dl	Inj. Hm-2 FU	The state of	TUM 134 MG
	8730	lbo mgld!	Try, Hm 25V.	م ا	
		0 , ,	T. GIRado 80,	W Bross	2 By Braveen
			7. Janumet 50/5	pany	
2 , 24	6.30	9 Angld.	10 Recheele (B)	K ?	do 16000
			After Breakfast		
	12.30	194 mg/dl	Zi HM 20 Under	Wash Ship	LB4.
				, V ₂ ,	

DIABETIC CHAR

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 hourly when stable) and adjust Insulin rate	150-200	Adjust Infusion rate to 2u / hr.
	according to the following Algorithm.	201-250	Adjust Infusion rate to 4u / hr.
	Target Bland 0 and 450 000 and	251-300	Adjust Infusion rate to 6u / hr.
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*	To monitor K+ separately.	351-400	Adjust Infusion rate to 10u / hr.
	Urine Acetone	>400	Adjust Infusion rate to 20u / hr.



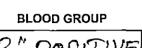




62/Male/MHI202381326 27/12/2023/12H2023002613

Dr.RAJESH.V





INVESTIGATION SHEET

	1 1			 .		_	 -
Date	19/12/23				1		
<u>HAEMATOLOGY</u>			ļ				
´Hb	14.0		<u> </u>	<u> </u>	<u>.</u>		
P.C.V	HIOT						
Platelets	249000						
TLC	7180			<u> </u>			
Polymorphs	59.0						
Lymphocytes	29.5						
Eosinophils	4.9	_	_		_		
Mono / Basophils	5.6/10						
E.S.R							
BIO-CHEMISTRY					,		
Urea	23_			<u> </u>			
Creatinine	0.00		<u> </u>	<u> </u>			
Sodium	139						
Potassium	4.43 23			<u> </u>			
Bicarbonate	23						
Chloride	99.7	·		<u> </u>	_		
Magnesium						_	_
Calcium	9.2						
Phosphorus	3-3		<u></u>				
LFT					_		
T.Bilirubin	0.43			<u> </u>			
D.Bilirubin	0.16						
I.Bilirubin	0.27						
S.G.O.T	23	_		<u> </u>			
S.G.P.T	30						
ALP	133		<u> </u>	ļ			
GGT	43	• • •		<u> </u>			
Total Protien	7.1			<u> </u>			
S.Albumin	4.2			<u> </u>			
CARDIAC ENZYMES							
Troponin!		\					
CKNAC - CPK							
CK - M.B. MASS							
LDH							
Ntpro bnp							
	<u> </u>						

	1-01-1-0					
Date	19/12/23					
<u>COAGULATION</u>	11.5 0.9					
PT / INR	10 -1		_			
Fibrinogen						
D Dimer APTT	23-7					
LIPID PROFILE						
Total Cholesterol						
Triglyceride						
H.D,L						
L.D.L						١
VLDV						
THYROID FUNCTION		_	_	,		
T.S.H	1-41		_	_		
T.3	17.0					
T.4	11.0					
SEROLORY						
HIV						
HBsAg	Hegalive					
V.D.R.L	1 Manage				-	
COVID 19						
RT- PCR		_				
lgM						
lg			,		į	
HBA1C	11.7					
FBS/PPBS	11-1					
RBS						
S.AMYLASE						
S.LIPASE				,		
C.R.P						
PROCALCITONIN						
DDIMER				-		
S.Osmolality				<u> </u>		
<u>URINE</u>	ļ		,			,
Osmolality	-					
Spot - Na						
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BLOOD GROUP

B POSTIVE

INVESTIGATION SHEET

Every heart beat

Mr.BALASUBRAMANI 62/Male/MHI202381326

27/12/2023/IPH2023002613

Dr.RAJESH.V

Date							
HAEMATOLOGY	Date	19.12.23	28 12 23	29 12 23	30/12/33	1/1/24	
P.C.V 41.7 36.2 34.5 32.2 Platelets 2.49000 223000 363000 293.00 TLC 7180 11530 112500 Polymorphs 57.0 16.1 67.7 Lymphocytes 29.5 14.5 92.3 Eosinophils 4-9 0.1 5.9 Mono / Basophils 5.6 / 1.0 9.0 6.3 5.4 6.4 E.S.R BIO-CHEMISTRY Urea 23 34 38 46 Creatinine 0.80 0.85 1.22 1.60 Sodium 139 138 Potassium 4.43 3.93 4.37 Bicarbonate 23 Chloride 99.7 Magnesium 9.2 Phosphorus 2.3 LFT T.Bilirubin 0.43	HAEMATOLOGY] ' '			, , ,	
P.C.V	Hb	14.0	12.2	11.2	10.9	1007	
Platelets	P.C.V			34.5	,,,	22.2	
TLC	 Platelets			253000		29700	
Polymorphs	TLC				_	112200	
Lymphocytes	Polymorphs					67.7	
Eosinophils			i				
Mono / Basophils 5-6 / 1-0 9.0 / 6.3 5-7 / 6.4 E.S.R BIO-CHEMISTRY 34 38 46 Creatinine 0.85 1.22 1.60 Sodium 139 138 1.38 Potassium 4.43 3.93 4.37 Bicarbonate 23 3.93 4.37 Chloride 99.7 1.6 1.4 Calcium 9.2 1.6 1.4 Phosphorus 3.3 1.5 1.4 LFT T.Bilirubin 0.43 1.6 1.4							
BIO-CHEMISTRY 34 38 46 Creatinine 0.80 0.85 1.22 1.60 Sodium 139 138 138 Potassium 4.43 3.93 1.37 Bicarbonate 23 3.93 1.37 Chloride 99.7 1.6 1.4 Calcium 9.2 1.6 1.4 Phosphorus 3.3 1.5 1.6 LFT T.Bilirubin 0.43 1.43 1.4						l f	
Urea 23 34 38 46 Creatinine 0.85 1.22 1.60 Sodium 139 138 Potassium 4.43 3.93 4.37 Bicarbonate 23 3.93 4.37 Chloride 99.4 1.6 1.4 Calcium 9.2 9.2 Phosphorus 3.3 1.6 LFT T.Billirubin 0.43	E.S.R	7 7 7		70		,,,	
Creatinine 0.80 0.85 1.22 1.60 Sodium 139 139 138 Potassium 4.43 3.93 4.37 Bicarbonate 23 23 Chloride 99.7 1.6 1.4 Calcium 9.2 1.4 1.4 Phosphorus 3.3 1.5 1.4 LFT 7.Bilirubin 0.43 1.43 1.4	BIO-CHEMISTRY				ļ		
Creatinine 0.80 0.85 1.22 1.60 Sodium 139 139 138 Potassium 4.43 3.93 4.37 Bicarbonate 23 23 Chloride 99.7 1.6 1.4 Calcium 9.2 1.4 1.4 Phosphorus 3.3 1.5 1.4 LFT 7.Bilirubin 0.43 1.43 1.4	Urea	23		34	38	46	
Sodium 139 138 Potassium 4.43 3.93 1.37 Bicarbonate 23 Chloride 99.7 Magnesium 1.6 1.4 Calcium 9.2 Phosphorus 3.3 LFT T.Bilirubin 0.43	Creatinine					T	
Potassium 4-43 3-93 4-37 Bicarbonate 23	Sodium				•		
Bicarbonate 2 3 Chloride 99.7 Magnesium 1.6 Calcium 9.2 Phosphorus 3.3 LFT T.Bilirubin	Potassium	-				i	
Chloride 99.7 Magnesium 1.6 Calcium 9.2 Phosphorus 3.3 LFT T.Bilirubin 0.43	Bicarbonate		İ				
Magnesium I · 6 I · 4 Calcium 9 · 2 Phosphorus 3 · 3 LFT T.Bilirubin 0 · 4 · 3	Chloride			_			
Calcium 9.2 Phosphorus 3.3 LFT T.Bilirubin 0.43	Magnesium	• • • • • • • • • • • • • • • • • • • •	1.6	١٠٨		•	
Phosphorus 3.3 LFT T.Bilirubin 0.43	Calcium	9.2					
LFT T.Bilirubin	Phosphorus	· ·	ì				
	LFT						
	T.Bilirubin	0.43					
ן אַר אַ אווים,טוו אַ אַר אַ אַר אווים,טוו אַ אַ אַ אַ אַ אַ אַ אַ אַ אַ אַ אַ אַ	D,Bilirubin	0.16					
I.Bilirubin の・2 字						_	
S.G.O.T 2.3	S.G.O.T						
S.G.P.T 30	S.G.P.T	30					
ALP 133	ALP						
GGT A3	GGT			-			
Total Protien 7-1	Total Protien			_			
S.Albumin 4.2.	S.Albumin						
CARDIAC ENZYMES	CARDIAC ENZYMES						
Troponin I	Troponin I						
CKNAC - CPK	CKNAC - CPK			271			
CK - M.B. MASS	CK - M.B. MASS						
LDH	LDH						
<u></u>	Ntpro bnp						

	 		ı		,	
Date	19.12.25			_		·
COAGULATION	19.12.25				,	
PT / INR	(, 3/0 /				,	
Fibrinogen						-
D Dimer APIT	22.7					
LIPID PROFILE						
Total Cholesterol						
Triglyceride				-		
H.D.L					_	
L.D.L						
V.L.D.V						:
THYROID FUNCTION				_	_	_
T.S.H) ⋅ t1					
T.3	150					
T.4	11.0		:			
SEROLORY	,, ,			-		
HIV				•		
HBsAg	MEGATIVE					
V.D.R.L	~ 41111	· .				
COVID 19		-		-		
RT- PCR						
lgM						
Ig						
HBA1C	11.7					
FBS/PPBS						
RBS						
S,AMYLASE .			<u> </u>		· ·	
S.LIPASE						•
C.R.P						
PROCALCITONIN				_		
DDIMER						
S.Osmolality			·			
<u>URINE</u>						
Osmolality						
Spot - Na						
Opot-Na						
				<u> </u>	<u> </u>	-
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					<u> </u>	

Medway Hospitals®
The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.BALASUBRAMANI

62/Malc/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V



VITAL INFORMATION SHEET

MHI/IP/2022/074

Medway

Heart

Institute

Every heart beat counts '

ON ADMISSION

Height in CM Weight in Kg.

168 cm Diagnosis: Procedure: CAD-TUD NO. OF DAYS DOA DATE 2 6 10 2 6 HOUR 40.5° 40° 39.5° 39° 38.5° 38° 37.5° RESP B.P. SPO2 DAILY WEIGHT 24 HRS INTAKE 24HRS OUTPUT 2000 mc BALANCE MOTION

AP Stopped on 23/12/22

62/Male/MHI202381326

Dr.RAJESH.V

27/12/2023/IFH2023002613







BSA:

BLOOD GROUP 1VE

ON ADMISSION

Weight in Kg.

1.85m2

VITAL INFORMATION SHEET Height in CM

		Mirin		194			.;																																						ŀ								\dagger							_
Diagnosis:		A'				<u> </u>		G	M	Q	L	V	. (Ξf	2 -	В	5	7	ı L				P	ro	се	du	re	: ()P	F	B	×	3	36	RI	AF	دراه	•							L			11	58	<u>80</u>	D			-	7 8	· K				_
NO. OF DAYS			20.				_	ור (10					D				20	D	_	<u> 1</u>	Ì	P	OE	ح	JV		₹.	7	ဉ်	<u>Ω</u> .	V				•																						_			
DATE		38	(12	, k	3	Ŋ	91	[در	ď	3	3	30	12		Ĵζ	2	31	l	2 '	2	3	t	11		2)	1	0	<u>.</u>			_ つ「	ان																												
HOUR	2	6 1	0 2	6	10	2	6	10	2 6	10	2	6	10	2	6 1	0 2	6	10	2	6	10	2	6	10	2	6 1	0 2	2 6	10	2	6	10	2	6	10	2	6 10	2	6	10	2	6	10	2	6 10	2	6	10	2	6	10	2	6 10	2	2 6	10	2	6 1	10	2
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38'	Ļ	H	‡	F	H	\dashv	1	,	‡	+			1	7	1	45					1	4	#	\dashv	\dashv	#	\ddagger	‡			H	#	7	7	#	#	‡	Ħ	ļ	Н	Ħ		\downarrow	#	ŧ	Ļ	F	H			#	1	‡	ļ	ŧ	ļ	H	#	1	_
37.5°	F		+	F	H	4	\not	\parallel	#	F	F)	1		*	r	925			\dashv		#	\dashv	7	#	#	$^{+}$	F		H	#	#	#	#	#	ŧ	F	F			7	#	#	Ŧ	F	F	H			#	#	#		Ŧ	F	H	#	+	_
37°	F	H	‡	<u>_</u>	Z	_	4	4	*	-		4	+	1	*	\$	P	1			4	~	*	4	4	+	‡	‡	-		H	#	\dashv	+	#	#	‡		+			+	#	#	‡	_	Ι.	Ц			#	#	+	1	‡	Ė	H	\downarrow	#	_
36.5°	F		1		\Box	\dashv	\downarrow	#	‡	ļ	Ë		1	+	‡	ŧ	ļ	ļ				_	#	\dashv	1	#	‡	‡	1		H	#	#	1	#	#	‡	Ļ	Ħ	Ħ		#	#	#	‡	H	L				‡	‡	+	Ļ	Ħ	F	Ħ	‡	†	_
369	Ł		\downarrow	F	\Box	\dashv	#	#	+	ļ			_	\downarrow	\downarrow	ŧ	+	‡	F		1		#	\dashv	#	#	#	$^{+}$			H	\downarrow	1	1	#	#	ļ	Ļ	ļ	H		\downarrow	#	#	‡	F	F	Н			#	#	†	Ħ	ŧ	F	Ħ	#	#	_
PULSE	T	Н	1:	1 0	4.	1	(ا	$\frac{1}{\sqrt{1+\epsilon}}$	50	ኍ ነት	٩	Į,	-	c,	<u>_</u>	a	μı	Ьlio	9	<u>'</u>	,,	浔	豆	5	8	1	+	<u>8</u> 8			ш	\dagger	1		\dagger	_1_			_	Ч			\top	L		T	_	Н	_'					t		_	Н		Ť	_
RESP	T		Ť	an.	_								6	٤	ę	Ť	0.1	0	3	D)		0	0		2	ř	=	Dr.)			T			T			T					1	_		T				-		_		İ			Ħ		1	_
B.P.			1	12	60	14	13	sųĨ	31	8	13	3/2	FT,	تمن	P	ااه	qρ	13	u	hel	90	ſλ	沤	ło	15	5/8	٥j	<u>80</u>	० ३	5		1																												_
SPO2				qί	V.	~	72	·/·	91	ě!		7(<u>) </u>	9	В		91	5%	/	9₿		ሳ:	4	Λ.	(8	1. 6	qj	14																															
DAILY WEIGHT		7	FP	λġ		- 2	30		re	F		36	al)	ďζ	ليلاح	Ĭ.	50	ماره	76	<u> </u>	-		<u>'</u>						1			\Box																											I	
24 HRS INTAKE		2:	<u>3.5</u>	<u> ۱ و</u>	M	_2	<u>.</u> 6.	<u>ь</u> Е		W	\Box)4(<u>ებ</u>	m	1		7	O	O	M	1	1	Щ	0	91	\mathbf{n}	4																\perp															_	\perp	
24HRS OUTPUT		2	૦૫	9	M	2	6	40		W	٢	37	<u>ત્રે</u>	01	Υ) έ	\int_{C}	9Ī	5	O.	m	L	Ź	α	5) <i>f</i>	n	ر ا	-																																
BALANCE		1.								W	Ŀ	દ	18	30	m	4	K	5	$\check{\sigma}$	'n	η.		Ê	2	<u>a</u>	U	<u> 7</u>	_				1											1											L						
MOTION					X								7	?		T	- 1	7	Ϋ́		<u>د</u> آ		0				T					T						Γ					T																	



62/Malc/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V



Every heart beat counts

FARLY WARNING SCORE MONITORING CHART

Name:					-	Age/Sex	:		Patient	Id No:	
NEWS key	DATE	Min	102/12	5-21	2 she						DATE
1 2 3		241	271	271	281						
	TIME	VADO	18.2	35.00	6.00						TIME
₹B	>25						3		-		>25
Respirations Breath/ min	21-24				-		2				21-24
oreatn/ min	18-20	19	-						_		18-20
	15-17 12-14	/-	-	-			+		_		15-17
	9-11	4					1				9-11
	<8		-	-		SHOW SHOW	-	-	-	Control of the last	9-11 <8
A+B	>96	-	-0	100	_	THE REAL PROPERTY.	-			CONTRACTOR OF STREET	>96
SPo2 Scale 1	94-95	/		The same			1				94-95
Oxygen Saturation (%)	92-93	1		1000			2			F-1000	92-93
	<91				2023		3				<91
Spo2 scale 2 oxygen	>96 on oxygen	DESCRIPTION OF THE PERSON OF T	W-25		E 6 1 2 3		3				>96 on oxygen
aturation (%) use scale 2 f target range is 88-92 % eg: in hypercapnic cospiratory failure only											
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
linician	>93 on air										>93 on air
	88-92										88-92
	86-87						1				86-87
	84-85					STATE OF THE PERSON.	2	DESCRIPTION OF THE PERSON	ALC: UNKNOWN	RESIDENCE MARKET	84-85
	<83%		2 9 3				3				<83%
Air or Oxygen ?	A= Air	-	-04	-62-							A= Air
	O2litre/ min	1					2				O2litre/ min
	Device /										Device
	>220	10000					3				>220
Blood Pressure		26.00									
	201-219										201-219
	181-200						2				181-200
	161-180										161-180
	141-160										141-160
	121-140	1		1	-						121-140
	111-120		06								111-120
	91-100						1				91-100
	81-90						2				81-90
	71-80						3				71-80
	61-70			98(10)			3				61-70
	51-60						3				51-60
	<50				0 4		3				<50
iastolic BP	mmHg				XT						mmHg
	>131			15,020			3				>131
ulse	121-130						2			TO SEE SEE	121-130
eats / min	111-120						2				111-120
	101-110						1				101-110
	91-100						1				91-100
	81-90		-	1							81-90
	71-80	1			0						71-80
	61-70	1									61-70
	51-60										51-60
	41-50						1				41-50
	31-40						3				31-40
	<30		198		5444	5500 NO. 1	3	PERMILE BUILD	100 EA 100	F-18 19 18 18 18 18 18 18 18 18 18 18 18 18 18	<30
	Alert	9	-	-	• •						Alert
onsciousness	Confusion	1					3 ()		100		Confusion
core for New onset of onfusion	V				72.28		3				V
no score if chronic)	P	125		1			3				P
no score ir chronic)	U					See 1978 - See 1	3 3		A A BASSA		U
	>39.1 degree Celsius						2				>39.1 degree Celsiu
emperature	38.1-39.0		10000		2000		1			-	38.1-39.0
egree Celsius	37.1-38.0	0	0		-						37.1-38.0
	36.1-37.0		/								36.1-37.0
	35.1-36.0				1000		1				35.1-36.0
	< 35.0	1	TO SEE		202,880	SERVICE DESIGNATION OF THE PERSON OF THE PER	3		THE RESERVE	THE REAL PROPERTY.	< 35.0
EWS Total		0	0	0	0.						133.0
Monitoring Frequency		1 10	LK	(17)	COTA						
scalation of Care Y/N		M	3.	1	M						
nitials by RN		an	Pon	'N	1	-					
nitials by Sr. RN		182	(00)	THE	100						
		1100	LMY	420	100	1	1 1	1	1 1	I I	

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



Mr.BALASUBRAMANI 62/Male/MHi202381326 27/12/2023/IPH2023002613





Every heart beat counts

EARLY WARNING SCORE MONITORING CHART

ALFORD I	DATE	1 61	2/12	-110	10V	.112	Sex:	2112	Leter	1-11/2	412	11/2	91112	47.12	MATE
NEWS key 1 2 3	DATE	2/12	3111	3111	311	310	310	31100	1/11/2	clin	1111	Viil	dill	1111	DATE
	TIME	1000	200	200	10.00	1how	Bir	22	som	Mag	10.00	into	M85-	9.00	TIME
#B	>25	No. of Concession,	ASSES.		RESERVE		EL SE	3	12022	Maria	NAME OF STREET	Name of Street	C. CARLOS		>25
espirations reath/ min	21-24 18-20				-	-	-	2		-		4		~	18-20
	15-17	•		-						,					15-17
	12-14														12-14
	9-11							1							9-11
	<8						To the	3			BEGGE A	No. 20			<8
1+B	>96	•	-	_	_	-	_	-	A.5-		_		-		>96
Po2 Scale 1 Exygen Saturation (%)	94-95							1							94-95 92-93
Aygen Saturation (76)	92-93	Service of the least of the lea	-	-	CONTRACTOR OF THE PERSON AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON A		-	2	20000000	Distance of	CONTRACTOR OF THE PARTY OF THE	CANCELLO	TOTAL PROPERTY.	THE OWNER OF THE OWNER,	<91
po2 scale 2 oxygen aturation (%) use scale 2 f target range is 88-92 % n hypercapnic iratory failure only	>96 on oxygen							1							>96 on oxygen
use scale 2 under the	95-96 on o2							2							95-96 on o2
irection of qualified	93-94 on O2							1							93-94 on O2
linician	>93 on air														>93 on air
	88-92							1	772 - 1						88-92 86-87
	86-87 84-85							2							84-85
	<83%	CARLES OF	2000	W. C. W.	A STATE OF	100000	SCHOOL ST	3		12 11 12	Sec. 1988	No.	10000	Section 1	<83%
Air or Oxygen ?	A= Air	12	R	- 7			~		2			-	-	,	A= Air
	O2litre/ min							2	Marie Control						O2litre/ min
	Device														Device
Blood Pressure	>220							3							>220
	201-219			V.	THE PARTY NAMED IN										201-219
	181-200		-		1000			2							181-200
	161-180														161-180
	141-160								_	-07				_	141-160
	121-140			_							4	-			121-140
	111-120		-		-	9	J.								111-120
	91-100							1	-						91-100 81-90
	81-90 71-80	Total Control	THE PERSON NAMED IN	-	THE REAL PROPERTY.	-	Name of Street	2	No. of Concession,	NAME OF TAXABLE PARTY.	No. of Lot, Lot,	DECEMBER 1	TO THE REAL PROPERTY.	All places	71-80
	71-80 61-70			7	1	10000		3	ESSENCE.					18/10/4	61-70
	51-60	1000000					PA PARE	3	142.50	278725		10000	100	17/200	51-60
	<50						10 TES	3	1		NEEDEN		1000	MARKET SE	<50
stolic BP	mmHg	30	90	20	80	744	79	92	70	20	80	80	80	82	mmHg
	>131	10000	1000	0		, ,	CLANE OF			DO ST	0.530		BIG AND		>131
ulse	121-130							2		-					121-130
leats / min	111-120							2							111-120
	101-110							1							101-110 91-100
	91-100 81-90							1							81-90
	71-80				-		_		-		_	-	-	-	71-80
	61-70		-	-				9-		-					61-70
	51-60														51-60
	41-50							1							41-50
	31-40							3							31-40
ALLEY MERCHAN	<30	10000	200	CARL	12.12.6		1	3	BERTH.	10000	No. of Concession, Name of Street, or other Persons, Name of Street, or ot	ELECTICAL PROPERTY.	-	10/ASD 5	<30
	Alert	+	•	-	-			7	2	>	9		-		Alert Confusion
consciousness core for New onset of	Confusion							3							V
confusion	P	1000000						3	No. of the last						P
no score if chronic)	U	1						3							U
	>39.1 degree				Real Property lies			2				The same			>39.1 degree Celsius
	Celsius		~	1											
emperature	38.1-39.0							1							38.1-39.0
Degree Celsius	37.1-38.0				-	-		0	-	05					37.1-38.0
	36.1-37.0						-			120	_	,	-	-	36.1-37.0
	35.1-36.0	No.				-		1	-	-	Contract of the last	Contract of the last	THE REAL PROPERTY.	Name and Address of the Owner, where the Owner, which is the Owner, where the Owner, which is the Owner, whic	35.1-36.0 < 35.0
NEWS Total	< 35.0	D.	D.	0	0	0	-	0	0	0.	0	2	0	0	- 33.0
Monitoring Frequency		ath	uth	UM	112	AA	1.6	un	Lutin	ugh	WK	non	for	416	
scalation of Care Y/N	MILES STATE OF THE	200	NO	NO	2	ne	COO	0.0	0.0	NO	P	NON	1001	K4 .	participation of the second
nitials by RN		Oh	6	8	SON,	and	est	1	100	'GZ	My	QC (90%	Jan .	
nitials by Sr. RN		27	2007	OF	Job.	19	20%	.07	1.000	and	100	000	199	0	
A STATE OF THE PARTY OF THE PAR	Note: Nurses	-	WIN	0711	12	TX.	Park	19.00	WO.	100	The same	Cars	- W	70	

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





Mr.BALASUBRAMANI 62/Malc/MHI202381326 27/12/2023/IPH2023002613





Every heart beat counts

Name:	6 宜 86	1 /04		Age/Sex:	Patient Id	1 No:
NEWS key	DATE	211	LII			DATE
1 2 3	TIME	6.00 m.c				TIME
	>25	6.0010-0	Maria de la companya del companya de la companya del companya de la companya de l	3		>25
espirations	21-24		I RESIDENCE OF	2		21-24
reath/ min	18-20	1 0				18-20
	15-17					15-17
	12-14					12-14
	9-11			1		9-11
ı+B	<8 >96	2 0	No. of Concession, Name of Street, or other Designation, or other		and the second second second second	>96
Po2 Scale 1	94-95	-		1		94-95
Oxygen Saturation (%)	92-93			2	Market Property and the last	92-93
	<91			3		<91
aturation (%) use scale 2 f target range is 88-92 % in hypercaphic	>96 on oxygen			3		>96 on oxygen
piratory failure only use scale 2 under the	95-96 on o2			2		95-96 on o2
lirection of qualified	93-94 on O2			1		93-94 on O2
linician	>93 on air					>93 on air
	88-92			1		88-92 86-87
	86-87 84-85			2		84-85
	<83%	W. C. C. C. C. C. C. C. C. C. C. C. C. C.		3		<83%
	100%					
ir or Oxygen ?	A= Air					A= Air
	O2litre/ min Device			2		O2litre/ min Device
Blood Pressure	>220			3		>220
	201-219					201-219
	181-200			2	SANCE THE RESERVE OF	181-200
	161-180					161-180
	141-160					141-160
	121-140	6 0				121-140
	111-120					111-120
	91-100 81-90			2		91-100
	71-80	Married World		3		71-80
	61-70			3		61-70
	51-60			3	BOOK BOOK BALLS	51-60
	<50	E 200 3 5 5		3	Action Charles Constitution	<50
astolic BP	mmHg	10 1	2			mmHg
	>131			3		>131
Pulse	121-130			2		121-130
seats / min	111-120			2		111-120 101-110
	101-110 91-100			1 1		91-100
	81-90			-		81-90
	71-80	-1-0				71-80
	61-70					61-70
	51-60					51-60
	41-50			1		41-50
	31-40	San San San Carlot		3		31-40
	<30			3		<30 Alert
) Consciousness	Alert			3	MATERIAL SECTION OF THE PARTY OF	Confusion
core for New onset of	V	BALL ST		3		V
confusion	P	CO CON ORS	TO THE PERSON NAMED IN	3	1450 March 200 M	P
no score if chronic)	U			3	SERVICE STATES SERVICES	U
	>39.1 degree Celsius			2		>39.1 degree Celsius
emperature	38.1-39.0			1		38.1-39.0
Degree Celsius	37.1-38.0					37.1-38.0
	36.1-37.0	- 6	ed.			36.1-37.0
	35.1-36.0			1		35.1-36.0
	< 35.0	0 0	THE REAL PROPERTY AND PARTY OF	3		< 35.0
NEWS Total Monitoring Frequency			N			
Scalation of Care Y/N		7 4	TA T			
nitials by RN		10 2	Q1			

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



Mr.BALASUBRAMANI 62/Male/MHI202381326

27/12/2023/1PH2023002613

Dr.RAJESH.V









								_							
Date	Fro	m: <u>•</u>	7 12/23 To	<u>מוצר : י</u>	ba Be	d No:	101-	<u> </u>				INTA	VE 9	OUT	DIIT
24 Hr	<u>'s : St</u>	arted Time	: 00 ·		Ended T	ime : 🔫	.00					INIA			FUI
NPO	Starte	ed at :			NP	O Over	at:						CHA	KK I	
SHIF	ī	N	lorning		Aftern	ioon			Nigh			Rest	ricted F	luid (R	F)
INTA	KE				48	0			<u>Ssor</u>	nt.					
OUT	PUT	- 8			537	0			550M1						_
Total	Intake:		omc.		Total Outpu	it: 1100	mc.			Differen	ce: <	<u>ട</u> ്ടാവ	<u></u>		
			INTAKE	(ml)						OUT	TPUT	(ml)	_		
Time	Oral	Tube		rous Infusio	on	विधि	Ti	I lain a	Varsitus	N/G	Drain	041	G~~~	DAI O	Endorsed
Tille		Feeding	Type of Fluid	Additions	Amount	(शिक्स	Time	Urine	Vomitus	Aspirate	Tube	Others	प्रविशि	KW Sign	by
14:00	ص		_			100	17-00	200					300		
'	150)				20	18.00		_				550		
180							11.30	<i>U</i> .(0			_		320		
19.00	l .					220	630	•			-	1 -	loom	ı	
-	3				 		19.05			_				<u>C.</u>	-
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62/Male/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V









Date	Fr	om: 3×1/2	-{2-3 To	D: 31/12-11	ა-ტ Be	d No: (14	_				INITA			
			e: 7,100.		Ended T							INTA			PUI
NPO	Start	ted at :			NP	O Over a	at:	_			_		CHA	KI	
SHIF	Т		Morning		Afterr	ioon			Nigh	t		Rest	ricted F	luid (R	F)
INTA	$\overline{}$	_			200 ml			3	Some	-				<u> </u>	
OUTF	דטי			بح	ooml			21	nom	<u></u>		<u> </u>	~ 2.2	(1+160c	4.
Total I	ntake	<u> </u>			otal Outpu	ıt:				Differen					
			INTAKE	<u>`</u>						OUT	<u> </u>	(ml)			
Time	Oral	Tube Feeding		Additions		Tiolel	Time	Urine	Vomitus	N/G Aspirate	Drain	Others	Total	R/N Sign	Endorsed by
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				100 11:30	BN 30	12 23									<u></u>
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										N NO		1 1			13002×

BALANCE - 2150m







Mr.Bi | UBRAMANI 62/Ms | HI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V





Date	Fro	<u>m: 3111</u>	12 23 1	o: 7-17 ₆ /	DA Be	ed No:						INITA	KE &	OUT	`דוום
24 Hr	s : St	arted Time	: 7:30 au		Ended T							IIVIA			FUI
NPO	Starte	ed at:			NF	O Over a	at:						CHA	'KI	
SHIF	T		Morning		After	noon			Nigh				ricted F		
INTA	KE	<u></u>	350		1150	5 *		26	00 ML	a .		PF-C	3,2	117+44	UL
OUTF	PUT		Fred		750			90	omL	•		<u> </u>			
Total	intake:	-			Total Outpu	ut:				Differen					
			INTAKE	<u> </u>						רטס	<u> </u>	\ 	2.00		
Time	Oral	Tube Feeding	Intravel Type of Fluid	Additions	T	, जिल्ला	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
Swo	150					180	9.30	3 50					B100		
lon	50						11,40	ļ					Jei		
1100	100			ļ		300	14,00	450				<u> </u>	950		
12.00	50			<u> </u>		300		300				<u> </u>	12-50		
12-3	0 U	P 7 8	9.00 1150	Jun In		1500.	20.00	500				<u> </u>	1750		
2400	100	-		<u> </u>		1600	5AM	400				<u> </u>	2150)	
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Mi LABUBRAMANI 62,:/MHI202381326 27/12/2023/IPH2023002613

Dr.Rajesh.v



(A Uni	I DI CIUCO AILE	Ed Hadicipal PT (CO)				1	•	CONTRACTO					Evr	ery heart	beat counts
Date			2 🔏 To	D: 212	Д Ве	d No: 44	×					INITA	 VE 0		'DUT
24 Hr	s : Sta	arted Time	: 7:30 ay	∞	Ended T	ime :						INIA	KE &		PUI
NPO	Starte	ed at :		•	NP	O Over	at:						CHA	KKI ———	•
SHIF	T		lorning		Afterr				Nigh	t		Rest	ricted F	luid (R	F)
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OUT			020.			<u>Ima</u>			# pom						
Total	Intake:		1400 mc	_	otal Outpu	ıt: 🐧	20M	L		Differen	7.1	COMC			
			INTAKE	<u> </u>							PUT	(ml)	No. 22 of		-
Time	Oral	Tube Feeding	Intraver Type of Fluid	nous Infusions		ीं जिल्ली	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	Total	R/N Sign	Endorsed by
7.00	150					150	7.00	350		_			350		
8-50	Boo			_		450	10.00	350					700		
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1380		\ \				700	16.00	<i>3</i> 00					1350		
14.30	MO	ļ				POD	29.0	tio o					1650		
1750	150					950	2.15	-,-				ļ	೨೦೦೨		
18-90	50					1000		,							
<u> 10:3</u>	100					1100									
200	100	,		_		1200						ļ			
<u>J. Do</u>	120					1850	<u> </u>	_			_	<u> </u>	·		
6.3	100					1400			70	TAC	NTA	KE -	402		
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Mr.BALASUBRAMANI 62/Male/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V









Date	Fro	m: <u>5</u>	To To	:3 L	2_(, Be	ed No:	1111					INITA	VE 0		'DIIT
24 Hr	s : Sta	arted Time	 		Ended T	ime : ~	f 00	•		·		INIA	KE &		PUI
NPO	Starte	d at:	, <u> </u>		NF	O Over a	at:						CHA	KI	
SHIF	Г	M	lorning		After	noon			Nigh	t		Res	tricted F	luid (R	[]
INTAI	(E	7	oo hil									P.F.	2.2	items	day
OUTF	דטי	. lo	xoo ndl												U
Total I	ntake:				Total Outpo	ut:				Differen					
			INTAKE	<u> </u>						OUT	<u> </u>	(ml)			<u>-</u>
Time	Oral	Tube	Intraver	nous Infusi		ीर्घां ।	Time	Urine	Vomitus	N/G	Drain	Othors	าสาย	R/N Sign	Endorsed
		Feeding	Type of Fluid	Additions	Amount		Time	Office	Volintus	Aspirate	Tube	Others	Total	icir oigi.	by
7-00	30 0 ·					000	4-20	350	_				350		
9-15							9.45	200					600		
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10.30	.200					500	12-00	350-	<u> </u>			†	1000	 	
12-15	200					60F						<u> </u>		<u> </u>	
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Every heart beat counts

Mr.BALASUBRAMANI

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

Dr.RAJESH.V



Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

us Beliefs: escription: ECTIVE	1600	Weight:	SINFOL, LO	rian La SaQ	Ehig	□ Egget	arian	☐ Jain
escription:	GLOBA	COURTON DO	(ADULTS)		المناك	0 - 1	<u> </u>	
ECTIVE	GLOBA	AL ASSESSMENT	(ADULTS)	n sal	thing	^ ~ 7		95.
ECTIVE	GLOBA	AL ASSESSMENT	(ADULTS)			P 1000	<u>coico</u>	distant d
		Patient's related Medical Histor			U			
		Patient's related Medical Histor	- 1 1	10	,		ı t _i	
						<u> </u>		
	<u> </u>	Weight Change (overall change	In past 6 months)				r.	
		/ □1	□ 2	<u>}□3 7 √ 1</u>	- 	-4	1	5
	6	No weight change/	<5×,	5-10%		10 - 15%	-	>15%
		gain		(, , ,	<u> </u>	<u>, ''</u>	1 1	
2)	Dietary Intake	Duration:				\ <u></u>	<u> </u>	
		-1	□·2 ·· · · · · · · · · · · · · · · · · ·	□ 3 <u>!</u>				□ 5
	Oral -	No change	Sub - optimal solid dies	/ Full liquid diet/ moderate overall decrease;	, · .	Hypo+ca liquid diet	:	Starvation
	Enteral/	Adequate /	Sub-optimal *	Inadequate		Туро - са	orle	Stanvation
	Parenteral Nutrition	Excessive			•	feeds		
3)	Gartraletestin	al Symptoms Duration:		1	- +	<u>'</u>	<u> </u>	
	- Gazaronikeson		□2				,	5
	1	No symptoms	Nausea	Vomiting/		Diarrhoea		severe anorexia
				moderate GI symptoms	•			
4)	Functional Ca	pacity (Nutrylon related functional impa		·		•		2
	·	<u>par : // / / / / / / / / / / / / / / / / /</u>	D2.	. □3	1	4	11.1	□s ·)
		None /Improved	Difficulty with ambulation	Difficulty with normal activity		Light	activity	Bed / thair - ridden with no
		2.300	- j 1 1	- I	•7 7			or little activity
ย	Co+ morbidity	! (Disease and its relationship to nutrition	requirements)	<u> </u>		,		
		□1 ; , i , ,		<u>, □., ,</u>	(,,++	7		5
		Healthy	Mild co -	Moderate			nt co-	Very severe
			morbidity	morbidit >75 year		, mor	bidity	multiple co = morbklity
3)	Physical exam	lination		1	<u>· 1 · · · · · · · · · · · · · · · · · ·</u>		`	
1)		stores or loss of subcutaneous fat	3 - 38 -	1 (1)	1 %	, -		
		6 3	□ 2	 				s
	 	Normal	Mild of A Control	Moderate	₹6	41.0	7	Severe
2}	Sign of muscle v		<u> </u>					
		1	.□2:	D3				D 5-
		Normal	Mild	Moderate		1 -1	1	. Severa ,
Yotal Score n S	um fabove 7 comp	enents .						(1) (1)
				- 		!	· i	
	tus : Based on this	patient is						
	Well Nourished)(7 to 14) + /		1, 1 , 1	·	
	Moderately Mai	nourished		(15 to 18)				
	Severely Malnor	urished		[19 to 35]				
						<u> </u>	'	
Nutrition Inter	rention:		-					
	001			Enteral .		Parenteral		
Diet counsellin		ATRE .		l No				
Frequency of r	e-assessments C	Weekly			Fort - night		☐ Monthly	

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
	M 62 years old gentlamen came to cho chest pain to paepitation & substing was paepitation as evident by SONA. 141Cto - TVD/pm/HTN. Educated the patient and panily on 1600 calories, low fety low salt, high protein, piabatic diet. Emphasized on Shall frequent masts to low geyenic control	Propose
28/12/23	patient shifted to or for surgerly (CABG). Kept on NBM. patient received to SICU. Ather over, be will initate Diabetic liquid diet as per doctor's advice. NBM over, patient itolonted Diabetic, eignid diet. can initate piabetic, soft soliding diet.	Proposers



Mr.BALASUBRAMANI 62/Male/MHi202381326 27/12/2023/IPH2023002613

Dr.Rajesh.v



Department of Dietetics

Every heart beat counts

CARE PLAN FORM - A

	<u> </u>	<u> </u>
DATE AND TIME	DIETITIAN NOTES	SIGNATURE
50/12/23 15:00	patient received to ward- nother re-emphasized, diet restrictions. motivated to cat well.	Qu-florsho:
2/1/24· to:00·	oral intake is good. Educated the patient of family on 1600 calories, Low fat, Low salt pigh protein, Diabetic diet on discharge:	Q-73086
:	Emphanized on a nove proquent meals and cow glycernic control. Diet modifications & classication done.	
·	diet chart given on discharge	

Department of Dietetics

CARE PLAN FORM - A

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
		· · · · · · · · · · · · · · · · · · ·
		*
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_	Contract to the contract of th	
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e)



Mr.BALASUBRAMANI

62/Malc/MHI202381326 27/12/2023/IPH2023002613

PSYCHOLOGICAL WELLBEING REPORT

Date: 82/01/24

Time: 12 2pm

Unit:

Clinical diagnosis:

Surgery/Procedure: OPCABX3 graffs (Pods)

functioning well, resistant to pen up I unvilling?

- calm affect, sviented, verpromise - sleep 9 appelite (1) - us projectors gical diskurs reported.

Employee ID: HHIOMPSY

Signature of the Psychologist:





	NTRAOPERATIVE NURSING RECORD
Mr.BALASUBRAMANI 62/Male/MHI202381326 27/12/2023/IPH2023002613	
Dr.RAJESH.V	Consultant: Dr. RAJESH.V
	AND THE STATE OF T
Name of Surgery . Ut	CABICLOSED HERRIJ Date of Surgery: 22 12 23
Mode of Transfer to OR	☐ Bed ☐ Stretcher ☐ Other ☐
Anaesthesia Type	: Epidural Spiral LOC MAC
	GEN Regional
Position	: Lithotomy Prone Supine Right Down Left down
•	□ Lateral ' □ Other □
Pressure Protection Pad	
•	Headrest Sand Bag Pillow Axillary roll
	Shoulder roll
	☐ Sling ☐ Boot ☐ Stirrups/Leg Holder
	☐ L aem rest padded / Sccured ☐ R Arms tucked / padded
	□ Nil □ R □ L □ Other (Specify)
Skin preparation in OT	☐ Nil ☐ R ☐ L ☐ Other (Specify)
	Alcohol Prep Others (specify)
Electrocautery	: Monopolar Dad Loacation Bipolar
Tourniquet	Location
	Applied Time Released Time
	Applied Time Released Time Released Time
Other equipment used	:
Personal	: Surgeon DY. PATESY DASS. PA-SADYUMART
	Anaesthetist Dr. PRAVEE ASS. DR. DR. VANANDAM
Type of Specimen	: —
Lab	: Pathology Permanent Frozen Time sent
	Cytology Time of report
	☐ Microbiology
	☐ Biochemistry

Packing / Drains / Catheters

Date & Time , 28/12/23-@ 13.30

Туре	Size	Site	Туре	Size	Amount	Sign
Ronson's	284	1086 Gransa	_	_		9
ROMSONS	78E1	mediaetinw	M			() 00B1
Urinoug Court	etheterizat Record	on done	by Mr. HAR	u USQ	d Har for	ey's calleter
Count	Sponges L	auze Gauze ined Unlined	Neuro Patties Tonsil. cotton balls	Canana	Bulldog clamp Need	sign Sign
Pre-op	con roth wi	net		Result	way way	y Su pasmi
Change over count	" " " " " " " " " " " " " " " " " " "	'ugar		l -412∼l	Λ(1)Λ(1)	$M/M/L_{\rm PO}$ $M/M/M/M$
First closure count	184 pt 12	Loope		more	recopy of soft	0031 0238
Final closure count	author a	Kelonk .		mulong Co	organ organ	sol palling
Corrective actio		/				
Surgeon inform	ed 					
الم\ك Dressing / G ast	haM areseil Immobilizer	ig done with a	eestle mapse,	leg Jvessi	ng Jone With &	ferile a passionere
Condition of pa	tient at end of	surgery :	Stable	Fair	☐ Critical	
Transferred to:			Patient Room	CCU	☐ Recovery I	Room
Name · RINI	したスプロプス	Mikaloa36 7/02041P4 7/2228	} A			
Date & Time:	28/12/25	36 13.30				
Circulating Nur Name; RIN	se Signature &	SUDO31 ARLOOS1				





62/Malc/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V





NURSING ADMISSION ASSESSMENT (ADULT)

	<u> </u>					
Date of Admission: The of Arrival: 12.60 Mode of Admission: W						
Accompanied by Relative. Yes No If Yes, Name of the Relative: +128 Physics WAR!						
Relationship with Patient: JOHUGHTER Rontact Person's Name: ROJOSWOOD Relationship: DAUGHTER						
Contact No.: 9941476652 Primary language spoken Tamil Englis	h Indian International					
Interpreter needed: Yes No	/					
Patient status: Conscious Unconscious Disoriented Patient Vulnerabl	e: Yes No					
Menstrual History: LMP: Menopause:						
Medical History: DM / H7N / Co - Morbility: 20/75 [Noves If yes specify						
Drugs History: Antiplatelet 23/12/23 (Specify) 7-Tingelog, Tel						
Psychological Status: Calm Anxious Withdrawn Agitated Depressed						
Do you have any special religious, spiritual or cultural needs to be considered? If Yes, specify details:	∐ Yes L Ayo					
Socio Economic Status: Employed Retired Own Business Home-Make	er Others:					
Vital Signs: Temp: 96.5 (°F) Pulse / HR:						
Respiration: 20 (breaths/min) SpO ₂ : 0, (%) CBG: 20 (mg/dl) Height: 16						
Allergies / Adverse Reaction: Yes No Medication Blood Trans	stusion Food Minot known					
If Yes, specify:						
Pain: Yes No. If Yes, Score: 010 Pain Scale Used: Wong-Baker FACI						
Numerical Rating Scale (>12 years)	CPOT (ventilator / comatose)					
Duration: Location:						
Pain Character: Dull Aching Sharp Stabbing Shooting Burning	Referred / Radiant Pain					
Nutritional Screening:						
Last 3 months Appetite: Increased Decreased No Change						
Last 3 months Weight: Increased Decreased No Change	on to cate of the					
Type of Faderia.	piabotic duel					
Dietician Informed: Yes No. If Yes, mention the Name: Drabolit H	2C. CATH Fime: 12,20					
Orient Patient if: Conscious Orient Patient Attendant if:	Inconscious Disoriented					
Room Side Rails Toilet Bell Patient Information Board	Sathroom Bed Controls					
Use of Footstool Grab Bars Nurses Call Bell Television	ight Controls					
Functional Assessment:						
Particular Assessment Remarks	Outcome					
Visual Impairment ☐ Yes☐ No	,					
Hearing Impairment Yes No						
Chewing Difficulty Yes No	-					
Walking Difficulty ☐ Yes ☐ No						

									,
Daily Activity Of L	iving:								,
Activity		Independe	ent	Assisted			De	Dependent	
Bathing						1			
Dressing		Ĭ							
Eating		<u> </u>				Ì			
Walking		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	-	_					
Toilet Use		T T			一			$\overline{\Box}$	
Pressure Injury Ri	isk Asses	sment: Brad	len Scale		•				
Sensory Percep	tion	Score	Moisture	•	Score	Degre	e of Activity	/	Score
No Impairment		. 3	Rarely Mois	t	14	- Walks	Frequently		A
Slightly Limited		3	Occasionall	y Moist	3	Walks	Occasional	у	3
Very Limited		· 2	Very Moist		2	Chair	Fast		2
Completely Limit	ed	1	Constantly I	Moist	1	Bed F	ast		1
Mobility		Score	Nutrition		Score	Fricti	on & Shear		Score
No Limitation		A	Excellent		3		parent prob		43~
Slightly Limited		3	Adequate	•	3	Poten	tial Problem		2
Very Limited *		. 2	Probably In	-Adequate	2	Probl	em Present		1
Completely imme	obile	1	Very Poor		1				
Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - High Risk: 12 - 10; Severe Risk: 9 - 6 Total Score: 23 Action needed: Yes No Pressure injury present at the time of a lifyes, Location: Grade: Siz Witnessed by: Signature: Relation					e of admissio Size:				
Fall Diels Assess		-	E FALL ASSES	SSMENT SC	ALE (Age a	bove 16	years)		
Fall Risk Assess Variables	sment (ivid	pairiea iviors	e Scale):					Nun	neric Value
							No	- NUII	0
History of falling	(immediate	e or within 6	months)				Yes		25
0							No		0
Secondary diagn	iosis (≥ 2	medicai diag	jnosis)				Yes		\15
Ambulatory Aid									
None / Bed Rest		ssist							0
Crutches / Cane Furniture	/ Walker	· · · · · ·							15
rumiture	 -		<u> </u>						30
Intravenous Ther	apy / Hepa	arin Lock / Tu	ubes Insitu				No		10
			 -				Yes		20
Gait Normal / Bed Be	st / Wheel	Chair							~ 0
Normal / Bed Rest / Wheel Chair Weak							10		
Impaired					•			-	20
Mental Status Oriented to own	stability							-	
Overestimated of		mitations							15
Medications			<u> </u>			<u> </u>			
includes PCA / o	piates, ant	ticonvulsants	s, anti-hyperter	nsives, diuret	ics, hypnotic	s,	No		0 _
laxatives, hypogl							Yes		15
Score Interpretation	ı: 0-24: Low	/-risk; 25-44: N	nedium Risk; Ab	ove 45: High F	Risk	Total Sc	ore		55

As per the score, tick the following appropriate	boxe	es:					
Familiarize the patient with the immediate surroundings Remind the patient to use call bell before getting out of bed Keep the two side rails in the raised position at all times for all patients regardless of age Keep the call bell, bedside table, water, glasses within the patient's easy reach Remove excess equipment or furniture to make a clear path Keep the patient's bed in the low position at all times except during procedure Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed Bed wheels should be locked Encourage family participation in the patient's care Ensure that floor of the bathroom is dry and not slippery Review medications for potential side effects that can promote falls Use safety belts during movement in wheelchair The patients are not ambulated by themselves. They are to be ambulated only with assistance Medium risk interventions (25 - 44) Apply all the low risk interventions (25 - 44) Apply all the low risk interventions (25 - 44) Apply all the low risk interventions Tie yellow fall risk tag in the bed and Wheel chair / Stretcher Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat Use restraints and bed monitors as ordered by the doctor Allow the patient to ambulate only with assistance Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care Do not leave patients unattended in diagnostic or treatment areas Accompany the patient while going to bathroom Advice the patient to use grab bars near the toilet, bathitub, and shower Make sure the family and other visitors understand the restrictions mentioned above High-risk interventions (above 45) Apply all the low and medium risk interventions Tie red fall risk tag in the bed, wheel chair and stretcher Locate the high-risk patients call bells as quickly as possible Provide a commode at bedside (i							
Urinal / bedpan should be within easy reach (if appropriate). Encourage family members or other visitors to stay with the propriate, consider using protection devices: safe	h then						
Initial Assessment to Special Needs and Vulnera	r	_					
· · · · · · · · · · · · · · · · · · ·	Yes	No	Remarks (please specify)				
Terminally ill patients							
Patients with intense chronic pain	1	\subseteq	·				
Woman in labor or experiencing termination of pregnancy							
Patients with emotional or psychological distress		\searrow					
Patient suspected of drug or alcohol dependency							
Victims of abuse and neglect		√	<u> </u>				
Patients whose immune system is compromised							
Patient with infections and communicable diseases			· · · · · · · · · · · · · · · · · · ·				
Does the patient have implants		$\overline{\ }$					
Has tracheotomy been done	1						
Has colostomy been done		$\overline{}$,				
Any other potential needs of the patient			· · · · · · · · · · · · · · · · · · ·				

DVT RISK ASSESSMENT Assign a score of 1 if (YES) in parameter nos. 1 to 9, and assign a score of -2 if (YES) in parameter no. 10 S. No. **Parameters** Yes / No Score Active cancer (on-going treatment or diagnosed within 6 months or palliative care) 1 Yes No 2 Νo 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 3 Yes (Assess for both legs) 4 Collateral (nonvaricose) superficial veins present (Assess for both legs) 5 Entire leg swollen (Assess for both legs) ∕ľ No 3 6 Localized tenderness along the deep venous system (Assess for both legs) Νo **(C)** Νo 7 Pitting edema, greater in the symptomatic leg (Assess for both legs) ()8 Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs) 0 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) 10 oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or \mathbf{C} 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 Too Low Risk -2 to 0 **Moderate Risk** 1 to 2 **High Risk** 3 to 8 Personal Belongings / Valuables: Name & Signature of the With With Patient's Valuables Description Remarks Patient / Patient's Attendant Patient Attendant □Upper □ Lower Dentures □Both 、□Nil □Right □ Left **Hearing Aid** Eye glasses / ☐ Yes ↓☐No **Contact lens** ☐ Yes √Z/No Jewellerv Other valuables (specify) Report (List of X-ray, ECG, lab reports retained with the nurse): Emp. No. Name Date Time Patient / Relationship Patient's Attendant DAUGHTER 20 Nurse **Unit In-Charge** 0005





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





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 2	7/12	2-3 Shift: 40	orning Evening	Night				
S	Ventilator Periphera Ryle's Tub Urinary Ca	EWS Score: QUE day:		GCS: IS POD: Central line VIP Score: es, specify organ	0/4			
В	Ou toom	irgery: — Fany: N1∠ L V×	wow cu	Date of surg	 -	·		
A	Others: Pain Sco Fall Risk Braden S	re: O Pain Scale us Score: Minimal Risk: 23-1 Ulcer Scale for Healing (字(%) Height:/6 sed: PIPPS / CRIES / F Protocol: □ Low □ N 9 □ At Risk-Mild Risk: 10	r_(cms) Weight ACC / Wong-Ba edium □High I-15□ Moderate R	: <u> </u>	27-7-) ng Scale / NR 12-10 □ Severe	S / Cl7 OT - e Risk: 9-6	
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: Two plan CABY							
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Dr.RAJESH.V





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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В	On room			, Date of surg , ·IV fluids on f	T. T		
A	BP: \2\frac{2}{2} Others : Pain Sco Fall Risk Braden S	reO10_Pain Scale used Score: 50_Fall Risk Pro Geore: 50_Fall Risk: 23-19 [Ulcer Scale for Healing (PU	_3(%) Height: 16 1: PIPPS / CRIES / FI otocol: □ Low JM □ At Risk-Mild Risk: 18	ACC / Wong-Baledium □High	ker FACES Pain Rat sk: 14-13 High Risk Dressing done: Ye	ing Scale / NR	e Risk: 9-6
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		Signature	Name	<u> </u>	Emp. No.	Date	Time
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62/Male/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 28	ود ا دا	Shift: ☑Morn	ing □Evening □ N	light				
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CPD → TVD PEWS Score: day: Il line day: Right: Left be: ☐ Yes ☐ No Day atheter: ☐ Yes ☐ No Day	<i>r</i> :	GCS: 15 POD: Central line of VIP Score: Decify organis	days:			
В		urgery: —	,	Date of surg				
A	Others: Pain Sco Fall Risk Braden S	re: O(10 Pain Scale used Score: Minimal Risk: 23-19 Ulcer Scale for Healing (PUS	3(%) Height: <u>/人名</u> (ci : PIPPS / CRIES / FLACG ptocol: □ Low	ms) Weight: C / Wong-Bak m	将るはkgs) BMI: <u>「</u> ker FACES Pain Ratin sk: 14-13 □ High Risk: Dressing done: □ Yes	D ∓ , ∓ fu g Scale / NR: 12-10 ∐ Seven	S / CPOT e Risk: 9-6	
R	Referral of Pending Pending Pending Critical va Changes	medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: ☐ Yes	_	are plan date	e:			
	Pending follow-up orders: Special instructions if any: To draw Plan LABU NPO MN 12.00							
		Signature	Name		Emp. No.	Date	Time	
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62/Male/MHI202381326 27/12/2023/IPH2023002613

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, i	PATIENT CLINICAL HANDOVER RECORD FOR NURSES								
Date: 👌	3/12/03	Shift: Morr	ning Vevening Night		_	٠,			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CAD - JVD PEWS Score: day: - al line day: RightCubi & Lef be:	Centi t: D / v: ViP s	ral line days: A	.		;		
В	Allergies On room	ROUND urgery: OPCAB if any: NKDA air / oxygen: ON OU GE nts / New Symptoms in last s	t į IV flui	of surgery: 🚜	. ,	;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;			
A	Others: Pain Sco Fall Risk Braden S Pressure	ns: Temp: 92- #(°F) Pulse # (mmHg) SpO.: 10 CVD - VIII Hg By ore: 40 Pain Scale used Score: 65 Fall Risk Pro	l: PIPPS./ CRIES / FLACC / Wo otocol: ☐ Low☐ Medium ☐ ☐ At Risk-Mild Risk: 18-15☐ Mod	Weight: 1843 (kg ong-Baker FACE:	gs) BMI: <u>=</u> S Pain Ratin □High Risk: Jone: □Yes	31-2 kg/m²- g Scale / NRS 12-10 ☑ Severe ☑No ☑NA	, Risk: 9-6		
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections	1	lan date:					
	•	Signature	Name	Emp. I	No.	Date	Time		
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	by Dr. provog.			
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	por chart			guis/007H
15.30	oral care givou.			
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62/Male/MHI20238132627/12/2023/IPH2023002613





F	PATIENT CLINICAL HANDOVER RECORD FOR NURSES						
Date: 28	Date: 28 12 2023. Shift: Morning Evening Night						
	Ventilator Periphera Ryle's Tut Urinary Ca	s: CAD - TVD PEWS Score: day: — Il line day: Right: Cub Poleto pe:	it:— D y: y: D y: D NR: □Yes ⊟No. If Yes, s	GCS: S 1 POD: DO: Central line VIP Score:	gdays: O_1		
В	BACKGI Type of su Allergies i On room a Complain	ROUND urgery: のPerrs メ ユ if any: NKDA air / oxygen: ON Nau its / New Symptoms in last s	Grafts al peorgs ylit-	Date of surg	lery: 28/12/205 low: KABIUT	2 <u>3</u>	
A	BP: 131 Others: _ Pain Scor Fall Risk Braden S Pressure	SMENT as: Temp: 1+ (°F) Pulse by (mmHg) SpO ₂ : 10 core: 10 Pain Scale used Score: 50 Fall Risk Pro Score: Minimal Risk: 23-19 [Ulcer Scale for Healing (PU liet: 2013 (00 (%) Height: <u> S.R.(</u> S.M	cms) Weight: CC / Wong-Bal um	斗名 (kgs) BMI:_ ker FACES Pain Rati	.31.21cd ing Scale (NR :: 12-10∐Severo	S_DEPOT = Risk: 9-6 . (n 01
R	Pending of Pending of	medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders:		•		uning.	
		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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19.30- DA-10		
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	monitoring patient is conscious oriented	,
	Gree-15/15 Pain some - 2/10	(Que 1001
<u>20.00</u>	patient had rice canjue really 1	
	bleratura well.	V. Dp. 1601
24.30	Alfbulization of spirometry quien	,
	Cheet physics quien	
22.00	patients wondition informed to	'
	Dr. Anbarary & Dr. Rajert	(1. Du 100)
23-20	Tuj. paracetamos Igm given ac	
	per chart.	(1. Dyrles;
01-30	patient had decreased output	<u> </u>
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01.30	patient I sleping well in comparta	
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0420	Blood sample toucen and Send to la	4
	separt to be.	
Os. 00	Dral care, gonge bath given, Ban	
	Care genen, soin interet.	(l. Opelo)
0\$ 30	Neue line case and catheter care give	<u>د</u>
<u> </u>	Nebulization and spowerly provided.	1
	fly Cepeuxine 1.5 gm given as per chart	
06.00	Paltant's Undelwin informed to 101. Anbo	wary
	of Dr. Rayerh admiced to Continue the same	· (. While)
06.40	ABU towen. In ABU, po, 61.8, 10t 3.4	~ [
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MI.BALASUBRAMANI 62/Male/MHI202381326 27/12/2023/IPH2023002613





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Date: 09 12	Date: $094 12 23$ Shift: Morning Evening Night								
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B	ype of s Illergies On room	ROUND urgery: OPCAB if any: NKDA air / oxygen: ON O, VC its / New Symptoms in last s		Date of surg	ery: 08 [12 23 ow: —	· ¢			
A F	Others: Pain Sco Fall Risk Braden S Pressure	SMENT ns: Temp: 100 2 (°F) Pulse 51	ら(%) Height: <u>Iら</u> る(ぐ よいらか) I: PIPPS / CRIES / FLAC otocol: □Low□ Medit □ At Risk-Mild Risk: 18-15	cms) Weight: CC / Wong-Bak um High Moderate Ri Wound D	太子 (kgs) BMI:_ ker FACES Pain Rati	ng Scale / NR: : 12-10□Severe s □No □NA	e Risk: 9-6		
R	Referral or Pending Pending Pending Critical va Changes Pending	imendation doctors: by prover medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders: instructions if any:	:	care plan date	; :-				
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	NURSES PROGRESS NOTES			
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9.00	Adnewinteral due Moderations as per			
	doctors order. Autidialistic drug added.			
9.30	Hodiapting and loft down down			I
	sour val ordered by pr-Anbaran.	PAC	Obus Cont	·#
10.00	Naturalization offen and offero			
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1.3.30	Dre modécations given.	,		<u> </u>
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	and values chality actory.	0 P	10 Out 100	\$ 4 ·
19.00	Signature Name Emp.		Date	Time
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Patic Mr.BALASUBRAMANI

Nam 62/Male/MHI202381326 UHIL 27/12/2023/IPH2023002613

DOB Dr.RAJESH.V DOA

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•	ATILITY CLINICAL HANDOVER RECORD FOR RUNSES					
Date:)	9/12/2	Shift: Morn	ing Evening Night			
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A	Others: Pain Sco Fall Risk Braden S Pressure	re: \tag{\text{P}} Pain Scale used Score: \tag{Minimal Risk: 23-19}	/ HR: \\ \(\) \(eight: + A. (kgs) BMI: g-Baker FACES Pain Ratingh rate Risk: 14-13 High Risk: und Dressing done: Yes	g Scale / NRS / CPOT	
R	Pending Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	July	n date:		
		Signature	Name	Emp. No.	Date Time	
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Document	Signature Name Emp.	No.	Date	Time
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	PATIENT CLINICAL HANDOVER RECORD FOR NURSES						
Date: 30	0/12/23	Shift: Morn	ning Evening N	ight			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CAD - JV J PEWS Score: day: di line day: Right: (Ub) ballefi be:	<i>!</i> :	GCS: FIP POD: TIP Central line of VIP Score: A Decify organis	OD days: 103 OF	_	
B	Allergies On rooper	urgery: OPCAB		Date of surge	ery: 08 (12 03 ow: —	·	
A	BP:] 신규 Others : Pain Sco Fall Risk Braden S Pressure	ns: Temp: <u>//tv</u> _(°F) Pulse (mmHg) SpO₂: <u>¶</u>	(%) Height: I S (cl 	ms) Weight: C / Wong-Bak m □ High Moderate Ris Wound D	구오 (kgs) BMI: er FACES Pain Ratin	31 · A / A / B / B / B / B / B / B / B / B /	
R	Referral of Pending Pending Pending Critical va Changes Pending	IMENDATION doctors: DY FOVEOU To medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: \(\text{Yes} \) follow-up orders: nstructions if any: \(\text{Yes} \)	3~1~	are plan date			•••
Handover g	given by	Signature	Name Dalha Florance		Emp. No.	Date 30 (2 23	Time
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	NURSES PROGRESS NOTES				<u>'</u>
Date & Time	Observations / Action		Signat	ture with E	mp, No.
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30/19	1 20	POXES.			
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<u> 4.30</u>	Due medérations given as per chort		RA	dagso	of <i>a</i>
8.00	The had state of Alli and todorate				- ,,
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<u>8.30</u>	Due hadischen given au por clar		RM	Mais 10	074.
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9.30	Abbulization grow with Guslin				
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9:45	Unobilized back to bad.		RN	Jane 3 / 000	f.4
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Mr.BALASUBRAMANI 62/Male/MHI202381326 27/12/2023/IPH2023002613





PATI	PATIENT CLINICAL HANDOVER RECORD FOR NURSES							
Date: 30/(2	Shift: Mor	ning Evening 🔲	Night					
Diagno: NEWS / Ventilate Periphe Ryle's T Urinary	SITUATION Diagnosis: CAD - US) NEWS / PEWS Score: POD: Control line day: Central line days: Peripheral line day: Right: Day: VIP Score: VIP S							
B Type of Allergie On room	Surgery: Opt Ab 13 s if any: 100+ Known m air / oxygen: 00 R ints / New Symptoms in last s	em en r	Date of surg	ery: 7-8(12(2) low: _)			
Vital Si BP: 10 Others Pain So Fall Ris Braden Pressu	ASSESSMENT Vital Signs: Temp: 16°F) Pulse / HR: 80 (beats/min) Respiration: 00 (breaths/min) BP: 10 (mmHg) SpO; 16 (%) Height/68 (cms) Weight: 78 (kgs) BMI: 31-2 (mmHg) SpO; 16 (%) Height/68 (cms) Weight: 78 (kgs) BMI: 31-2 (mmHg) SpO; 16 (mmHg) SpO; 16 (mmHg) SpO; 17 (mmHg) SpO; 18 (kgs) BMI: 31-2 (mmHg) SpO; 18 (kgs) SpO; 18 (kgs) SpO; 18 (kgs) SpO; 18 (kgs) SpO; 18 (kgs) SpO; 18 (kgs) SpO; 18 (kgs) SpO; 18 (kgs) SpO; 18 (kgs) SpO; 18 (kgs) SpO; 18 (kgs) SpO; 18 (kgs) SpO; 18 (kgs) SpO; 18 (kgs) SpO; 18 (kg							
Referra Pending Pending Critical Change	RECOMMENDATION Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: Critical value alert and its corrections: Changes in nursing care plan: Yes No. If Yes, modified care plan date: Pending follow-up orders: Special instructions if any:							
	Signature	Name	/	Emp. No.	Date	Time		
Handover given by		A-MONIS	The.	01h1	30/12/2	19-130		
Handover taken by	(C)	12111 Blue	-con-e	0271	30 12/2	102.80		
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62/Male/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V





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Date: 2	1/2/2	Shift: Morr	ning Evening Night		-	
S	Ventilator Periphera Ryle's Tul Urinary C	s: CPO - TV D PEWS Score: - day: al line day: Right: D Lef be: Year No Day catheter: Yes No Day	t: VIP Score:	०१७	,	
В	Allergies On roóm	ROUND urgery: OPCP BX if any: NKD A air / oxygen: PP, nts / New Symptoms in last s	. IV fluids on fl	,	2123	>
A	BP: (C) Others: Pain Sco Fall Risk Braden S	re: O LAPain Scale used Score: Minimal Risk: 23-19 Ulcer Scale for Healing (PU	/ HR: (beats/min) Respira	ker FACES Pain Ratinsk: 14-13 High Risk: Oressing done: Yes	1.2 ay/ ng Scale / NR 12-10 Sever	S/CPOT
R	Pending Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections	✓ VI (☑No. If Yes, modified care plan date):		
		Signature	Name	Emp. No.	Date	Time
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62/Mule/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V





Every heart best-counts

Date: 3t	lia la	Shift: Morr	ning □Evening □Night		.020			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	S: CAD - CVD PEWS Score: 0 day: Il line day: Right: Dy Lef De:	y: VIP Scor	ne days:				
В	Type of surgery: DRABX 3 94/6 Date of surgery: 28/12/23 Allergies if any: NKOA On room air / oxygen: PA Complaints / New Symptoms in last shift: W//							
A	ASSESSMENT Vital Signs: Temp: 9/-4(°F) Pulse / HR: 80 (beats/min) Respiration: 6 (breaths/min) BP: 40/70 (mmHg) SpO ₂ : 98 (%) Height: 8 (cms) Weight: 78 (kgs) BMI: 31-2 kg/m² Others: Pain Score: Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: Fall Risk Protocol: Low Medium High Braden Score: Minimal Risk: 23-19 At Risk-Mild Risk: 18-15 Moderate Risk: 14-13 High Risk: 12-10 Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): Yes No No NA Wound Dressing done: Yes No NA Current diet: Diabelia List							
R	Pending (Pending Critical value) Changes Pending (Pending Sending edications: medication indent: ab reports / Investigations: alue alert and its corrections	:	date:					
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62/Male/MHI202381326 27/12/2023/IPH2023002613



(A Unit of U	Inited Alliance Healt	hcare Pvt Ltd)			Eve	ry heart bea	£-counts	
PATIENT CLINICAL HANDOVER RECORD FOR NURSES								
Date: 3	1/12/	23 Shift: Morr	ing Evening Nigh	ht i	, !			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	S: CAD CONTROL OF SECOND CONTR	PC Ce VI	CS: 15(OD: entral line d IP Score: (cify organis	5/5			
В	Allergies On room	ROUND urgery: OPCels A 3 if any: NXD A air / oxygen: R A nts / New Symptoms in last s	IV	ate of surge	ow: _	3		
A	ASSESSMENT Vital Signs: Temp: 18-2 (°F) Pulse / HR: 78 (beats/min) Respiration: 20 (breaths/min) BP: 1/0 80 (mmHg) SpO ₂ : 91/2 (%) Height: 1/58 (cms) Weight: 78 (kgs) BMI: 31/2 (**) Others:							
R	Referral of Pending Pending Pending Critical vo Changes Pending	IMENDATION doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:	This If Yes modified care	المصحف	ne, Not,	et T	o Lovi	
•		Signature	Name		Emp. No.	Date	Time	
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NURSES PROGRESS NOTES								
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	25/6 Monites			$\widehat{\mathbf{D}}$				
16.00	·		<u>ک</u> '	2333				
18 - 30	=> CBG was Checked & seemed	_ `	E 4-	~ °				
10-30	-> pt V/s Checked & xelorded -> pt T/o Chart maintained -> pt well mobilized		F.Ca 020	07				
19,30	It handled over to night de staff	uty	F. (at;				
		F ••						
Document endorsed by	Signature Name Q. Nalihi	Emp. No.		21/12125	Time බ්හ\ර			







N: 62/Malc/MHI202381326 U 27/12/2023/IPH2023002613

Dr.RAJESH.V





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	PATIE	NT CLINICAL F	IANDOVER I	RECORI	D FOR NUR	ISES	1.		
Date: 2	1/12/2	Shift: Morn	ing Evening [/]	Night .					
S	NEWS / F Ventilator Periphera Ryle's Tul Urináry C	EWS Score: day: line day: Right: Left De: Yes No Day atheter:		GCS! ST	ol5	<i>;</i>			
В	BACKGI Type of si Allergies On room Complain	ROUND argery: OPCABX = f any: NKDA air / oxygen: PA ts / New Symptoms in last si	39.80J-73	Date of surg	ery: 2-8(12) ow:	23,			
A	ASSESSMENT Vital Signs: Temp 8-2°F) Pulse / HR:								
R	Pending 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:	_	, Nat		oval p	lan		
		Signature	Name	•	Emp. No.	Date	Time		
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NURSES PROGRESS NOTES								
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62/Malc/MHI202381326 27/12/2023/IPH2023002613





PATIENT CLINICAL HANDOVER RECORD FOR NURSES								
Date: [∫j	23	Shift: Morn	ing Evening Night					
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	TUATION agnosis: CAD - T-VD GCS: J J WS / PEWS Score: O POD: Intilator day: Central line days: ripheral line day: Right: Left: le's Tube: Yes No Day: VIP Score: O nary Catheter: Yes No Day: rrier nursing: Yes No MDR: Yes No. If Yes, specify organism:						
В	Allergies On room	ROUND urgery: OPCAR & 3 ge if any: NEDA air / oxygen: EA ts / New Symptoms in last s	IV fluids	surgery: 28 /12/23	i			
A	ASSESSMENT Vital Signs: Temp: 96 (°F) Pulse / HR: 86 (beats/min) Respiration: 90 (breaths/min) BP: 30 80 (mmHg) SpO ₂ : 98 (%) Height: 18 (cms) Weight: 78 (kgs) BMI: 37 2/G / m2 Others: 91 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: 50 Fall Risk Protocol: 0 Low Medium High Braden Score: 0 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): 0 Yes No NA Ourrent diet: 0 10 5 6 7 C							
R	Referral of Pending Pending Pending Critical vo 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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NURSES PROGRESS NOTES								
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62/Male/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V





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Date: [111.20	Shift: Morr	ning Evening N	light `	, , ,	·	<u>.</u>	
S	NEWS / F Ventilator Periphera Ryle's Tu Urinary C	S: CAD - TOD PEWS Score: day: day: Al line day: Right: P be:	y:	GCS: (p) (A) POD: Central line of VIP Score: specify organis	days:		, , \	
В	On room	ROUND urgery: のPCAの & B if any: vood IAn e v air / oxygen: en との ats / New Symptoms in last s	m w	Date of surg , IV fluids on fl	ery: 🗪 8 (12/14) ow: —),		
A	ASSESSMENT Vital Signs: Temp: 966F) Pulse / HR: 60 (beats/min) Respiration: 20 (breaths/min) BP: 100 fto (mmHg) SpO ₂ : 70 (%) Height: 60 (cms) Weight: 78 (kgs) BMI: 3/- 2/- 2/- 2/- 2/- 2/- 2/- 2/- 2/- 2/- 2							
R	Referral of Pending Pending Pending Critical via Changes	imendation doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders: instructions if any:		care plan date	:			
		Signature	Name	1	Emp. No.	Date	Time	
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62/Male/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V





PATIENT CLINICAL HANDOVER RECORD FOR NURSES							
Date:	1/21	Shift: ☐ Morr	ning Devening Night		·		
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	S: CD C C C C C C C C C C C C C C C C C C	POD: 1	O(5)	· · · · · · · · · · · · · · · · · · ·		
В	Type of st Allergies On room Complain	urgery: ND CARX S	0.00	surgery: 2-8 12 on flow:	122		
A	BP: 20 Others: Pain Sco Fall Risk Braden S	ns: Temp: 2°F) Pulse FO (mmHg) SpO ₂ : 9 ore: Pain Scale used Score: Fall Risk Pro Score: Minimal Risk: 23-19 [Ulcer Scale for Healing (PU		ight 3 2 (kgs) BMI: g-Baker FACES Pain Rati	31. Q Frim ng Scale / NRS / CPOT : 12-10 Severe Risk: 9-6		
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections	1 1 1 1	date:	-		
		Signature	Name	Emp. No.	Date Time		
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NURSES PROGRESS NOTES								
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2/1/27	Night (Shrtay Notes						
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Pat Mr.BALASUBRAMANI

Nat 62/Mulc/MHI202381326

UHI 27/12/2023/IPH2023002613

DOI Dr.RAJESH.V





PA	TIE	NT CLINICAL Ḥ	IANDOVER RECOR	D FOR NUR	RSES	İ		
Date: 2	23	Shift: Morn	ing Evening Night	. ' .		,		
S Pe	entilator eriphera /le's Tul inary C	i: (A) - (V) EWS Score: 0 day: I line day: Right: Left De:	: VIP Score:	oays:				
B Ny All	pe of su lergies in room	ROUND Irgery: ORABY 3 GRA fany: NKI) A air / oxygen: RA ts / New Symptoms in last sl	IV fluids on fi	rery: 28 /12/2_ low: —	n _.	:		
Vi BF Of Pa Fa Br Pr	ASSESSMENT Vital Signs: Temp: 7FH°F) Pulse / HR: 89 (beats/min) Respiration: 0 (breaths/min) BP: 10 86 (mmHg) SpO ₂ : 98 (%) Height: 8 (cms) Weight: 78 (kgs) BMI: 31 - 2 kg Others:							
Re Pe Pe Ci Ci Ci Pe	eferral c ending i ending i ending i ritical va hanges ending i	MENDATION doctors: medications: medication indent: dab reports / Investigations: alue alert and its corrections: in nursing care plan: ☐ Yes follow-up orders: hstructions if any: ☐ H !—	No. If Yes, modified care plan date	e:				
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2/1/234	Mo	ening Duty Notes			·	1
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ADULT NURSING CARE PLAN

Mr.BALASUBRAMANI

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





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Initial Date: 2+12	In \geq Time: $\leq -\infty$	Modified Date: Time:		
Reason for Modification:	· .	Diagnosis: CAO - TV.O.		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION Keep NPO Regular Diet Others:	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	M + tolies E pt tolies D dear	Joh
			Polint had 10M diet	
OXYGENATION Air Nasal Cannula / High Flow O ₂ BiPAP /-CPAP Ventilator	Patient will have normal O₂ saturation □ Patient ABG levels will return to and remain within normal limits □ No other respiratory abnormalities □ Patient respiratory rate will remains within established limits	□ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises □ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order □ Utilise pulse oximetry to check O₂ saturation and pulse rate □ If any O₂ abnormalities detected inform immediately to	М	
☐ Tracheostomy ☐ Others:	Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis Note for changes in level of consciousness	E Cles	Feef
		Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging patient with successful coughing	Patient 1'8 on Room Air -	
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition	Patient will have balanced fluid and electrolytes balance	☐ Enhance fluid intake unless restricted ☐ Check IV sites and assess if there is any complication ☐ Provide tube feedings ☐ Monitor intake and output	M	
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 oral	John
			N Churt Monitoral	

Ratient 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	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment	M	
U 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)	EP+ mobilized	Sol
		. (Patient Mobilized well	P.
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement Urination	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence,	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's /	M	
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	E ladeig	Sef
		Check for malena / constipation / urinary retention	Normal Elimination	
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE	Patient will maintain normal healing status Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Min(mize 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	
INJURY GRADE-1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status		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 maintained Skie	45. Å
☐ PUSH Decreased☐ PUSH Increased☐ Intermittent Assisted☐ Dermatitis☐ Pressure injury / blisters site			Main fain Normal	Afra
care given Others:			N (Strains) (aut 1/oita)	Ph.
	<u>l </u>		TAININ THATTHEY	

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 Chànge patient's gown daily Encourage hand hygiene Consider the patient's need for assistive devices Apply moisturizing solution	M EP+ taker Self Batient wall grooms	Sel Par
SAFETY Check ID-Hand IV care EJV CENTRAL LINE Side rails Others:	Patient will have no life-threatening situations	Sheck 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)	E TD Based	Sel.
COMFORT AND SLEEP Pain Centrel Steep 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 EDT Sloops of recol Composition	Seel D
OBSERVATION Vital Signs GCS Blood Sugar Others:	Patient will have normal range of vital parameters		M E D+ vitals all Checked NYfal Digns Chapted	Seef
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 	M E Patroit Support	

Patient Specific Problems / Needs	Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATION] Verbal,] Non-verbal] Sigh language] Others:	Patient will communic with positive feedback	ate effectively '	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's or prognosis in the patient's presence	condition	Ms. A	nael califor good munication	20Y
SPECIAL INTERVENTIONS Medication Wound care Isolation Ostomy Care Blood / Blood products transfusion Fluid tapping DVT Management Others:	☑ 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 b blood products and fluids Monitor DVT score and continue treatment as per doctors order	solation ensure blood or	М	vdication Giver	
Signature		Name		Emp. ID	T.	Date	Time
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62/Male/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V





ADULT POST-OPERATIVE NURSING CARE PLAN

ADULI FUST-UF ENATIVE NUNSING CARE FLAN						
Initial Date: 28/12/2	Time: 13.45	Modified Date: — Time: —				
Reason for Modification:	· · · · · · · · · · · · · · · · · · ·	Diagnosis: CAD - TVD				
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	M E Ministered pholosoius N palient hard tolerable (Que pain a les in les mention 151			
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 E SPD, - 100%. Jain Toots Patient is comfortable Non Naial prongs 4lit Neb & Spice 10 sources tot			
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 in 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 E NA NA			
MOBILITY Mobile / Improbile 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 E ON bad nest down to the North N Drain precent			

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE Oral Intraverious 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	E JV (ine potent and healty Notal of its fluids	08450-14 11.194
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 deplie plantiens (plowd. (N followed in all aspects or rations care	Vanda V. Ogu
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. E fall Yik prouder fallon N Capety precaulturi followed	ORUB V. Ore-
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 drain involte. (N Swigical Eilt intact	V. Or
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	E ON IVF 1000 h. Dahent u tolerating Nemisolid diet	1014 1014 1.19m

Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
CARE OF CAT DRAINS, ETC.		Patient will have pater maintained catheters,		Check the catheters, drains etc frequentl Observe I/O Chart Watch for any symptoms related to kinke blocked tubes Maintain adequate cleaning and dressing	ed or	M E ON CBP Observer N Mainteen Cleaning	adequale of	
DISTURBED B	ODY IMAGE	☐ The patient will demo initial acceptance and body image		Note non verbal body language, negative and self talk Note emotional reaction (grieving, depre Acknowledge and accept expression of to grief and hostility	ssion, anger)	M E N MA		
OBSERVATION Vital Signs GCS Blood Sugar Others:	N .	Patient will have norm of vital parameters	nal range	Monitor vital signs regularly Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient		M E-Haemodyna N Patienti	Micely Stollo 1 hamodynam	04450+4 V.252
HEALTH EDUC Patient Patient Gamily / 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 / Gua Domestic Partner / Ca others will gain adequ knowledge regarding modalities and life sty modifications	are-giver / uate treatment	Provide proper education regarding follor Insist on importance of hand hygiene Explore action, reactions and adherence Provide clear, thorough, and understands regarding safety precautions. Explain to perform activities / skin care the by concerned doctor Use the teach-back technique to determine understanding regarding importance of the standard services.	about medication able explanations at recommended ne the patient's	S S S S S S S S S S S S S S S S S S S		Claus St. 2
ANY OTHER N	EEDS				-	M E N		
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62/Male/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH,V





ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 29 12 2	3 Time: 7:00	Modified Date: — Time: _		
Reason for Modification:		Diagnosis: (AD - TVD		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation Madication	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,	M order of Australia E administration modication	Ofenis Openis
	,	swelling, separation and drainage Non-Pharmacological therapy	N Proceed Compital	0276
OXYGENATION Room Air Oxygen Hood Nasal Cannula	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	M OPS-964. ON (Verdi (20-14
Nasai Cannula Nebulizer Ventilator Others:	,	Monitor rate, depth of respiration Administer oxygen and nebulizer therapy if needed Encourage spriometry, deep breathing and	E SPOJ- 90%. ON YOOM	
,	,	coughing exercises Monitor amount, viscosity, colour and odour of sputum if present	N On Room Air	3570
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 Ha L cooperative	Oracio AA
☐ 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 / Improbile 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 ON Book sent (100 th
☐ 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 an chair fast	Paus ta
·	adaptive devices to increase mobility	localized swelling, a rise in temperature)	n moss brod	\$750

Patient Specific				Sign &
Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	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 Maritored Jo, administered due maliculian. E & line parant and hoditus. N & healthy	Paris A September 1
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 daptic proguetar followed: E deptic proguetien Use d official Noncounters Followed	Conta Conta Conta Conta
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 proceedies E fall risk procedies N Fall risk procedies N proceedies	Charles of the State
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 inglita E would haditue N wound hoostty	Vans +4
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 dof E ON liquid dof N Soft all of	Mijota Mijota

Patient Specifi Problems / Ne		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
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 ON CER UTINO CONFERT E ON CER CITIVO OUTPUT Adequate N ON CER, adams	g.
DISTURBED B	ODY IMAGE	The patient will demonstrate initial acceptance and to newly body image	Note non verbal body language, negative attitude and self talk Note a metional reaction (articles, decreasion and a)	M	
		body image	 Note emotional reaction (grieving, depression, anger) Acknowledge and accept expression of feeling of grief and hostility 	E	
				N	
OBSERVATIOI ☐ Vital Signs	N	☐ Patient will have normal range of vital parameters	Monitor vital signs regularly Assess physically for any abnormality	m Houndepartally stable	Phyir actor
GCS Blood Sugar Others:			☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient	E flag wood greenically Otable	days
_ Guioro.				N Homodynamicaly	0350 0350
HEALTH EDUC Patient Family / Guardi	ian	Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment	Provide proper education regarding follow-up diet Insist on importance of hand hygiene Explore action, reactions and adherence about medical Provide clear, thorough, and understandable explanations.		Shuit acts
Disease proces Infection contro Medication Educate about and immunosu	of / PPE TAC level appressant	modalities and life style modifications	regarding safety precautions. Explain to perform activities / skin care that recommen by concerned doctor Use the teach-back technique to determine the patient understanding regarding importance of treatment	E GINDON KHOWADON ON	Dada OFA
Personal Safety Treatment Regi	y imen			N pt condition a 200 stay	8
ANY OTHER N	IEEDS			M	
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	·			N .	
	Signature	Name	Emp. ID	Date	Time
Endorsed by	2		Aman'	30/12/23	92





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Dr.RAJESH.V





ADULT POST-OPERATIVE NURSING CARE PLAN

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Initial Date: 30 12	23 Time: \$100	Modified Date: Time:		
Reason for Modification:	· 	Diagnosis: AD-IVD		
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 Allientered oralgences	Levi of
Pain Score Others:			Eprovided popular	OM
		swelling, separation and drainage Non-Pharmacological therapy	N Provale Com	P 25
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 Shorton Or. Ou	ORIO DA
☐ 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 Spor 987	SOIH!
		coughing exercises Monitor amount, viscosity, colour and odour of sputum if present	NSP02-98%	027
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 in simple language they understand □ Encourage and support patient while increasing	M Cooperated well-	Mai de
Anxious Look	surroundings	anxiety level Help patient to cope with outcomes of surgery	E	
		Keep patient in comfortable position in bed to enhance sleep	N L	
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 ON chair fast	OD JA
	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,	Ept mobilised	ON SIN
; 	adaptive devices to increase mobility	localized swelling, a rise in temperature)	N Mornicine	Box

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 Stine parland as healthy E 260 chost wis monitorsed N manitorsed	Charles Conty
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 Apophic Foothbroad. E N	Xout)
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 foll 19)K prosuften E N Provide 8 ide N pain up	Rooff Best
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 coand halfing E N —	Paul 1
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 Jawi Mod diet E PF herd Oref N P+ herd O	San Pari

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Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign _• & Initials
CARE OF CAT DRAINS, ETC.		Patient will have patent, maintained catheters, d		Check the catheters, drains etc frequentl Observe I/O Chart Watch for any symptoms related to kinke blocked tubes Maintain adequate cleaning and dressing	ed or	M ON CBD Output E X o dus	mon ron	Ton Grond
DISTURBED B	BODY IMAGE The patient will demonstrate initial acceptance and to πewly body image		 Note non verbal body language, negative and self talk Note emotional reaction (grieving, depre Acknowledge and accept expression of tof grief and hostility 	ssion, anger)	M E N			
OBSERVATION Vital Signs GCS Blood Sugar Others:	N	Patient will have normal of vital parameters	ر I range	Monitor vital signs regularly Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient		M flackwood	Stan 10	Jans Solh (
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 / Guard Domestic Partner / Care others will gain adequa knowledge regarding tr modalities and life style modifications	e-giver /	□ Previde proper education regarding follo □ Insist on importance of hand hygiene □ Explore action, reactions and adherence □ Provide clear, thorough, and understand regarding safety precautions. □ Explain to perform activities / skin care the by concerned doctor □ Use the teach-back technique to determine understanding regarding importance of the standing regarding importance.	about medication able explanations nat recommended ine the patient's	hygicae Com		Vande Foota
ANY OTHER NEEDS						M V		
						N		
	Signature		Name		Emp. ID	.,	Date	Time _
Endorsed by	A			Lunaii	2003		30/14/13	2.00

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ADULT NURSING CARE PLAN

Mr.BALA	RRITE	AMA	NT
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Nt 62/Male/MHI202381326 UI 27/12/2023/IPH2023002613

Dr.RAJESH.V

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Modified Date: Time: Initial Date: CAD-TUD Reason for Modification: Diagnosis: Patient Specific Sign & **Nursing Interventions Measurable Goals** Evaluation Problems / Needs Initials ☐ Patient will have adequate nutrition Provide Prescribed diet on time NUTRITION with no nausea and vomiting Encourage patient to consume the served meal Keep NPO Regular Diet Patient will consume daily nutritional Record amount of food consumed requirements in accordance to his Others: activity level and metabolic needs Patient will have normal O₂ saturation **OXYGENATION** Encourage chest physio / deep breathing and Room Air Patient ABG levels will return to and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory ■ Nasal Cannula / High Flow O. remain within normal limits ☐ No other respiratory abnormalities☐ Patient respiratory rate will remains □ Mask medications / Oxygen as per doctors order ☐ BiPAP / CPAP Utilise pulse oximetry to check O₃ saturation and pulse rate ☐ Ventilator within established limits If any O₂ abnormalities detected inform immediately to the concerned physician Roo~ ☐ Tracheostomy Patient will indicates, either verbally Place patient with proper body alignment for maximum or through behavior, feeling Others: Ε breathing pattern comfortable when breathing Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis ☐ Note for changes in level of consciousness. Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging patient with successful coughing Enhance fluid intake unless restricted ☐ Patient will have balanced fluid and FLUID'& ELECTROLYTES Check IV sites and assess if there is any complication □ Oral electrolytes balance Provide tube feedings Intravenous Enteral Nutrition ☐ Monitor intake and output ☐ Parenteral Nutrition Measure or estimate fluid losses from all sources such ☐ Others: as diaphoresis, wound drainage, and gastric losses ■ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes

* <u>************************************</u>				
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
Møbile/Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease P-tient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment Consider the need for home assistance (e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M P+ mobilized well E yobilized N Mobilized N Mobilized	John Dass
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Sowel movement Urination Others:	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	☐ Encourage fluid intake ☐ Encourage fibre diet intake ☐ Encourage early ambulation ☐ Report any abnormalities to physician ☐ Observe voiding accessories as foley's / silicone catheter ☐ Check placement before feeding ☐ Aspirate NG tube, check colour / consistenct / volume / Hernetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention	M Self voiding Elimination Flimination N was good.	Pohn (2) 37 . (2) 52 4
SKININTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE INJURY GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased Intermittent Assisted Dermatitis Pressure Injury / blisters site	Patient will maintain normal healing status Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	Mointains normal M Stin E Maintain (N)	Rest n_
care given Others:	·		Mouint ain (N) No Strin But egrity	Q 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 Pt well gworned. E groomed well N groomed	Par
SAFETY Check ID Hand IV care EJV CENTRAL LINE Side rails Others:	Patient will have no life-threatening situations	Check the identity with ID band before any interaction with the patient Raise side rails Provide proper invasive line care Keep bed locked and low at all time Educate care providers to be the patient Follow restrain policy (if needed)	M 10 bades) E ID bad D N Rd hand	18/2 18/2 19/2 19/2 19/2 19/2 19/2 19/2 19/2 19
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 - Chellop M - N -	0 3
OBSERVATION Vital Signs GCS Blood Sugar Others:	Patient will have normal range of vital parameters		M vijal signs stable E US G Stable N VIS Cherred N G recorded	84/n 253) Q 257
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	M Provided Psychological Support E N	

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Patient Specific Problems / Need		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATION Verbal Non-verbal Sigh language Others:	ON (Patient will communic with positive feedback	ate effectively	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patier or prognosis in the patient's presence	t's condition	M Effective	- worder om musicalin comme castion	PH2
!						N GOOD	menieux	The second
SPECIAL INTER Medication Wound care Isolation Ostomy Care Blood / Blood protransfusion Fluid tapping DVT Managemen Others:	oducts	To manage on time		Double check for high alert medication Observe and report any medication received provide proper measures of wound cather follow hospital polices and protocols of and explain to the patient / family Check for cross matching and typing, compatibility Practice strict asepsis while transfusing blood products and fluids Monitor DVT score and continue treatmas per doctors order	action re of isolation o ensure pblood or	E medic N Machi	edrons gim chalt edlon give outfor ron cuf.	Cash Cash
9	Signature		Name		Emp. ID		Date	Time
Endorsed by		Nag	٤	. Nalini	O6 20	+	31/12/03	12:00
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ADULT NURSING CARE PLAN

Mr.BALASUBRAMANI

62/Malc/MHI202381326

UH 27/12/2023/IPH2023002613

DO Dr.RAJESH.V



Initial Date: 111202H Time: 7.130		Modified Date: Time:		
Reason for Modification:		Diagnosis: CAD - TVD		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Hegular Diet ☐ Others:	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	M Takes districted E PT had @pot N Ptrocol (N) dry	Josh Part
OXYGENATION	Patient will have normal O₂ saturation Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	□ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises □ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order □ Utilise pulse oximetry to check O₂ saturation and pulse rate □ If any O₂ abnormalities detected inform immediately to the concerned physician □ Place patient with proper body alignment for maximum breathing pattern □ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis □ Note for changes in level of consciousness □ Send sputum for culture and sensitivity based on physician order □ Maintain clear airway by suctioning or encouraging patient with successful coughing	M Patiet is on com air	Josha Josha
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 Takes adoquite ord fluids E Sho chest was Noted Shourt Mount 108 his	Postn_

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign 8 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 P+ mobilized well	Polla
Others:	Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	Consider the need for home assistance (e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	E. 18th mobilities.	En!
	(n Pf mobiliza	Q d
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 self voiding	Pobla
Others:	lrination 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 perthera D	Of all
		and follow proper protocol Check for malena / constipation / urinary retention	N Flimer attour	
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment	Patient will maintain normal healing status Patient will discharge with intact skin integrity	Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices	No object in Surgical site	out.
HAPI □ OPI GRADES OF PRESSURE INJURY GRADE 1 □ GRADE 2		 □ Early skin inspection and treatment □ Keep position changing 2 hourly and manage pain □ Manage moisture, clean and dry skin □ Maintain adequate nutrition and hydration 	Surgical site	Posto
GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased		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:			Marintour N D Strin	

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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE ☐ Bed-Bath ☐ Assist-Bath	Patient will stay clean and well-groomed Patient will demonstrate lifestyle	☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene	Mpt will goomed	PAR
☑ Self-Care ☐ CBD Care (if present) ☐ Others:	changes to meet şelf-care needs Patient will recognize individual weakness or needs	Consider the patient's need for assistive devices Apply moisturizing solution	E	
· · ·	,		NP+ Well grooms	OF THE
SAFETY Gheck ID Hand IV care	Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails	M 10 bord D	Josl 2
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 SD kind D	1 Solh!
,	,	Follow restrain policy (if needed)	N Folkard.	(B)
COMFORT AND SLEEP	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:	tterns behavior about pain relief and adequate sleep		E	
`'	,		N	
OBSERVATION Vital Signs GCS	☐ Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality	M Vibal signs stable	Post 12
☐ 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 streple	ON IN
		,	N VIO Mooked	DIH.
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 Pervi ded Psychological	puln
☐ 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	
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Sigh anguage Obtain interpreter if needed No negative speaking about the patient's condition or prognosis in the patient's presence Prognosis in the patient's presence Prognosis in the patient's presence Prognosis in the patient's presence Prognosis in the patient's presence Prognosis in the patient's presence Prognosis in the patient's presence Prognosis in the patient's presence Prognosis in the patient's presence Prognosis in the patient's presence Prognosis in the patient's presence Prognosis in the patient interpreter if needed No negative speaking about the patient's condition Prognosis in the patient's presence Prognosis in the patient's presence Prognosis in the patient's presence Prognosis in the patient's presence Prognosis in the patient's presence Prognosis in the patient's presence Prognosis in the patient's condition Provide prognosis and reduction Provide prognosis of wound care P		Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
Sigh language Others: No negative speaking about the patient's condition or prognosis in the patient's presence Prognosis in the patient's	✓ Werbal with positive feedback		Encourage the use of call bell		long (one	whi cotton	Posla			
SPECIAL INTERVENTIONS To manage on time Double check for high alert medication Double check for high ale	☐ Sigh language			☐ No negative speaking about the		E'PA cor	monisore	Fans,		
Medication Observe and report any medication reaction Provide proper measures of wound care Isolation Ostomy Care Isolation Ostomy Care Isolation Ostomy Care Isolation One of the patient / family Otheck for cross matching and typing, to ensure compatibility Practice strict asepsis while transfusing blood or blood products and fluids Monitor DVT score and continue treatment As per doctors order Others: Signature Name Emp. ID Date Time Date Time Date Time Dat		·						n Pt Cor	nm whicotion	8591
Blood / Blood products transfusion Fluid tapping DVT Management Others: Check for cross matching and typing, to ensure compatibility Practice strict asepsis while transfusing blood or blood products and fluids Monitor DVT score and continue treatment as per doctors order Signature Name Emp. ID Date Time	Medication Wound care Isolation Ostomy Care Blood / Blood products transfusion Fluid tapping DVT Management		Observe and report any medication reaction Provide proper measures of wound care Follow hospital polices and protocols of isolation		M	Las	Poblar			
Signature Monitor DVT score and continue treatment as per doctors order N Meeti Cert ON OF ON OTHER OF ON OF ON OTHER OF ON OTHER OF ON OTHER OF ON OTHER OF ON OTHER OF ON OTHER OF ON OTHER OF ON OTHER OF ON OTHER OTHER OF OTHER OTHER OF OTHER OT				☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or		e medl.	ren ren	Poin		
1,194 (bi			☐ Monitor DVT score and continue treatment		n meeti given	certion am.	2 rot			
Endorsed by 109 1. Nalin 0024 111124 16			Signature		Name		Emp. ID		Date	Time
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ADULT NURSING CARE PLAN

Pati' Mr.BALASUBRAMANI
Nam. 62/Melle/MHI202381326
UHIL 27/12/2023/IPH2023002613
DDB: Dr.RAJESH.V
DOA:



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Initial Date: 2)1(2)	1 Time: 7:30	Modified Date: Time:		
Reason for Modification:		Diagnosis: CAO - TVO		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sìgn & 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 Takes Diabetic del	fast o
Others:	requirements in accordance to his activity level and metabolic needs		E	
			N	
OXYGENATION Boom Air Nasal Cannula / High Flow O ₂ Mask BiPAP / CPAP	No other respiratory abnormalities Patient respiratory rate will remains	□ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises □ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order □ Utilise pulse oximetry to check O₂ saturation and pulse rate	M Patiet is on	Joshn
☐ Ventilator ☐ Tracheostorny ☐ 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 	E	
		□ Note for changes in level of consciousness □ Send sputum for culture and sensitivity based on physician order □ Maintain clear airway by suctioning or encouraging patient with successful coughing	N	
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 Takes adagente M Oval fluids E	Bostn
			N	

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

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Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE Bed-Bath Assist-Bath Self-Care CBD Care (if present) Others:	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs Patient will recognize individual weakness or needs	Encourage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene Consider the patient's need for assistive devices Apply moisturizing solution	M pt well ground	Alm.
			N	
SAFETY Check ID Hand IV care	Patient will have no life-threatening situations	Check the identity with ID band before any interaction with the patient Raise side rails	M 1D band @	Postn
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	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		E /	
		The second secon	N	
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar	Detient will have normal range of vital parameters		M Vital Signs Stable	Postn
Others:		□ Monitor GCS of patient □ Determine and treat the underlying cause of altered LOC □ Regular blood sugar monitoring as per doctors order	E	
			N	
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 Provided psychologic Suppost	Postn
☐ 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	
<i>y</i> - 541.515.			N	

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ı	Patient Specifi		Measurable Goals		Nursing Interventions		Evaluation		Sign &
	Problems / Nec	TION /	Patient will communic with positive feedback	ate effectively	Introduce the care giver Encourage the use of call bell Obtain interpreter if needed No negative speaking about the patient's or prognosis in the patient's presence	condition		- verbal unication	Initials
							N		
 	SPECIAL INTE Medication Wound care	RVENTIONS	To manage on time		Double check for high alert medication Observe and report any medication react Provide proper measures of wound care		Medical M as per ch	Fors given	Lostin
	☐ Isolation ☐ Ostomy Care ☐ Blood / Blood p transfusion ☐ Fluid tapping				 Follow hospital polices and protocols of is and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing b 	ensure	E		
	☐ DVT Manageme	ent			blood products and fluids Monitor DVT score and continue treatment as per doctors order	nt	N		
ŀ		Clamatuma		Name		I		Data	Time
I		Signature		Name		Emp. ID		Date	1
	Endorsed by	Signature	Dag		. Naliñ		<u> </u>	2/1184	16:00

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

Dr.RAJESH.V





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





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

Dr.RAJESH.V





Every heart beat counts

Date: 18 12 20 12

	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK	ime: 8 2	2012	_
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 vert commands. Has no sens deficit which would li ability to feel or voice pair discomfort	ory mit	2_	2
MOISTURE degree to which skin is exposed to moisture	Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen or requires changing at rou intervals		2_	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 le twice a day and inside ro at least once every two ho during waking hours	om .	1	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 with assistance		2	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	meat or diary products per day. Occasionally will take a dietary	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	Never refuses a me Usually eats a total of A	eal. 4 or and nally loes	2	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 independentl strength to lift up completely during move. Nor chair			2_	2
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction			TOTAL SCO Initial & Emp. I of Staff Nur	~	11 11	12
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. I of Sr. Staff Nur	No.	10-	





Mr.KALIYAN S

71/Mulc/MHI202381394 27/12/2023/IPH2023002614

Dr.Anbarasu mohanraj





Every heart beat counts

Date: 29 29

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK Date:		29]k	
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	3	3
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very-Molst Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals		ر و	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		م	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		م	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	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	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	<u>ይ</u> 	2	2
FRICTION	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	assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. Nor chair	Maintains good position in bed	2	· c⁄	2_
& SHEAR	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. of Staff Nurse:	13 2002 1002	13	13
Score	Interpretation: Minimal Risk: 23 - 19; At Risk (I Mild Risk: 18 - 15; Moderate Risk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	Q	N.	N.





Patient Mr.BALASUBRAMANI

Name: UHID:

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

DOB: DOA:

Consul

Dr.RAJESH.V

MHI/NUR/2022/045 MeBway

Every heart beat counts

Date: 14

	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	YRISK _ Time:	12,	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	cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	A	
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Molst Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Molst Skin is usually dry, linen only requires changing at routine intervals	14	7	
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	H	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	ケ	41	
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 autritional 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	Н	
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. Nor chair		\$_	3	
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair		TOTAL SCORE	ا	2 Q	
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & Emp. No. of Staff Nurse:	DN EAL	07	+
Score	Interpretation: Minimal Risk: 23 - 19; At Risk	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; F	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	عوا 24	160-	





Patie<u>nt Details (Affix Label here)</u>

Nam Mr.BALASUBRAMANI

UHII 62/Malc/MHI202381326

DOB 27/12/2023/IPH2023002613

DOA Dr.RAJESH.V

MHI/NUR/2022/045

Heart
Institute

Every heart beat counts

Date: 12 22

	BRADEN S	CALE FOR PREDICTI	NG PHESSURE INJUR	Y RISK Time	u_{μ}	12 F	23 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	10	7	4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately ofice a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4	Jef
ACTIVITY degree of physical activity	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	١.	4	
MOBILITY ability to change and control body cosition	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		27	Ц
NUTRITION usual food ntake 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	H
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum	2. Potential Problem Moves feebly or requires minimum' assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair	3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. Norchair		3	3	3
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & Emp. No. of Staff Nurse:	Poth	277	R
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:	24	شقق ا	27





62/Male/MHI202381326

JI 27/12/2023/IPH2023002613

DC Dr.RAJESH.V





Every heart beat counts

Date:

	BRADEN S	CALE FOR PREDICT!	NG PRESSURE INJUR	Y RIS	SK Time:	M	F	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	Respo comma deficit	npairment onds to verbal nds. Has no sensory which would limit ofeel or voice pain or fort	4	भ	4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring ap extra linen change approximately once a day	Skin is u	Rarely Moist kin is usually dry, linen only equires changing at routine ntervals		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	Walks of twice a at least	s Frequently butside room at least day and inside room once every two hours waking hours	4	J.F	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	Makes	mitation major and frequent s in position without nce	4	H	j.
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	Never Usually more s diary pr eats be	lient nost of every meal. refuses a meal. eats a total of 4 or ervings of meat and oducts. Occasionally etween meals. Does uire supplementation	4	K	4
FRICTION	Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently.	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably-slides to some extent against sheets,	3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. No	y and ha	as sufficient muscle good position in bed	3	స్త	3
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair			TOTAL SCORE	23	93	2
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down			Initial & Emp. No. of Staff Nurse:	Roff		
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Rísk: 14 - 13; I	High Risk: 12 - 10; Severe Risk: 9 - 6		Initial & Emp. No., of Sr. Staff Nurse:	245	24	1 11 12 12





Pati Mr.BALASUBRAMANI
Nai 62/Malc/MHi202381326
UH 27/12/2023/IPH2023002613
DO Dr.RAJESH.V
Co



(A Unit of United Al	liance Healthcare Pvt Ltd)		CO 114 UNI UNITURE SERVICE UNI	Evergi			
	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Date:)_ }	27)
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4		
MOISTURE degree to which skin is exposed to moisture	1. Constantly 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	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			
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 nutrifional 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		
FRICTION	Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,			_3		
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair		TOTAL SCORE	23		
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & Emp. No. of Staff Nurse:	Roll		
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:	24		







62/Malc/MH1202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V



MHI/NUR/2022/052



PAI	N RI	E-ASSESSMENT	& MC	NITORING	CHART	Every heart I	beat counts
Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senlor Staff Initial & Emp. No.
مدال	0/10	NO pai				Helfor	Con the second s
18-a	olo	N/O DULL	٠		<u>د</u>	20	Op.
<u> </u>		No pair	1	-	•	P _A	OP of
28.112/2 200	<u>.</u>	No Pain	-	_	F-	R	Co Co
6.00		No pain	1		_	P	OPK.
		V					
				-			

Date & Timè	Pain Score	(dull, achy	Pain Character , sharp, stabbing, shooting, ,, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
14.								
		,						١
		,						
		, , ,	· ·		P/	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 seven	le comfort me		un .	, , ,	• •
(38 we	CRIES eks - 2 m	onths)				of gestation. A maximal score of 10 is possible. If the CRIES score is > esic administration is indicated for a score of 6 or higher.	4,	,i ,
	ACC Sca nths - 7 y		0: Relaxed & comfortable	e, 1-3: Mild di	scomfort, 4-6: Mode	rate discomfort, 7-10: Severe discomfort / pain / both		
Paln	-Baker FA Rating Sars - 12 ye	cale	O 2 No Hurts Little Bit	(©) 4 Hurts Little More	6 Hurts Even More	Numerical Rating Scale (age 10	1 1 5 7 8 1 1	years) 9 10
Observa	cal care F tion Tool tor / com	(CPOT)	COMPLIANCE WITH VE	Absence of m NTILATION (li Libated patier lelaxed, 1 - Te	novements or normal ntubated patients): (nts): 0 - Talking on no nse, Rigid, 2 - Very Ta	osition, 1 - Protection, 2 - Restlessness / Agitation - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fightin mal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing nse, Rigid	g ventilator (or)	
	harmacol tervention		Cutaneous Stimulation a Thermal Therapies (no lo	nd massage: onger than 15	E - Positioning; F - P to 20 minutes): G - C	- Music; D - Physical and mental exercisers ubbing / Massage the skin Id application; H - Hot application; I - Shortwave diathermy erferntial therapy Psycho-social therapy/counselling: K - Individual Cou	nseling; L - Famil	/ counseling
Pharmac	ological l	nterventio	ns as per doctor's prescrip	tlon				



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Mr.BALASUBRAMANI

62/Malc/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V



MH!/NUR/2022/05



Date &	Pain	Pain Character (dull, achy, sharp, stabbing, shooting,	Duration	Location / Site	Interventions	Staff Initial	Senior Staff Initial &
Time	Score	burning, referred / radiant pain)	``			& Emp. No.	Emp. No.
13.45 O13.45	1/10	doll pain	e loi Nee	Farman	Non pharmacological management show	Obus Oota	Noo
18.30			lo-15	Agraum	Phannalological managament dans.	Olowo Confa	N. or
17.30	1/10		LIF Vao	drain site	,	Charle Sta	0/090
19.30	2/10	Aely pain	العصدا	cterniem.	Mon- phaemaeological intermenter provided	ri. V. Or	(603)
J1.30	1/20	Deell pain	Sseer	Bauc ·	provided comfortable position	K. Qu	Dowy
<u> </u>	2/10	Achy pain	10000.	Steenum	phæmaiological intermention proceeded	101 1.10m	Kors
29/12/2 01·30		, v	eeping			(. Au-	0003
02-30		patient is Ste	seping			1. Qu	Soos
OS·30	2/6	Dul pain	losen	Banc	provided compatable position	(; p)	A 3000

Date & Time	Pain Score	(dull, achy	Pain Character , sharp, stabbing, shooting, g, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.		
	2/10	0	dely pain	KIR Are	drainalthe.	Pharmacological Managouring Jour	Olaws 20 H	Nov.		
Ø1.30	1/10	d	all prin	10-15	Storaum	Non phonocological un vagament dono.	Abul 2014	Aoos		
11-30	1/10	، ، ا	full fortion	210 210	Avoin side	Non promper logical uprogramment done.	South Joseph	W 000		
13-30	1/10	du	ll-pain	Vio	Arain situ	Confortable populies origin	Agus fr	Just 1		
	,	,			<u> </u>	IN SCALES (, <u>f</u>			
(28 week	PIPP\$ (8 to <u><</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to severe	le comfort me		•	1"			
(38 we	CRIES eks - 2 m	onths)				of gestation. A maximal score of 10 is possible. If the CRIES score is $>$ 4 esic administration is indicated for a score of 6 or higher.	,			
	ACC Sca nths - 7 y		0: Relaxed & comfortable	e, 1-3: Mild di	lscomfort, 4-6: Mode	rate discomfort, 7-10: Severe discomfort / pain / both				
Pain	-Baker F/ Rating S ars - 12 ye	cale	O 2 No Hurts Hurt Little Bit	4 Hurts Little	6 Hurts Even More	Numerical Rating Scale (age m Numerical Rating Scale (age m Numerical Rating Scale (age m Numerical Rating Scale (age m Numerical Rating Scale (age m Numerical Rating Scale (age m Numerical Rating Scale (age m Numerical Rating Scale (age m Numerical Rating Scale (age m	7 8	9 10		
Observa	cal care I itlon Tool itor / com	(CPOT)	COMPLIANCE WITH VE	Absence of m NTILATION (II Libated patier lelaxed, 1 - Te	ovements or normal p ntubated patients): 0 nts): 0 - Talking on no nse, Rigid, 2 - Very Te	position, 1 - Protection, 2 - Restlessness / Agitation - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fighting rmal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing nse, Rigid				
Non-pharmacological Interventions Distraction: A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers Cutaneous Stimulation and massage: E - Positioning; F - Rubbing / Massage the skin Thermal Theraples (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy Transcutaneous electrical nerve stimulation (TENS): J - Interferntial therapy Psycho-social therapy/counselling: K - Individual Counseling; L - Family counseling										
Pharmac	ological i	nterventlo	ns as per doctor's prescrip	tion						

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PAIN RE-ASSESSMENT & MONITORING CHART

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Mr.KALIYAN S

Non pharmacological management dow.

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

Dr.ANBARASU MOHANRAJ

MHI/NUR/2,022/052



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.
29/12/2 15:30	16.30	Acly pain	15 G	O DOYAU M	Now pharmacological management down	Ofaut?	Moods
	17.30	dull-pain	lo-iñ	Modashinen		Glow to	Room
19-30	Yw	Dull pain	210 SDC	gungical	un planacoungeal Entervention dere	9Th	000
1.30	1600	Dull Pain	SDC	Sternum	Nen-phonnacouogecap Protoruention done	र्व कर्मिक	ציטס א
33-30		pulfont	V	o s glep	e real	551	L sou
30/12/j		patte	nt	Le 21	ept well	Of some	Loos
03-30		Pati		٠		र्शन्त	Your
05,30	\ .	Dr. Du Dom	210	Stomum	non-Pharmacocogy coul	部和	N 200

Date & . Time	Pain Score	(dull, achy	ain Character , sharp, stabbing, shooting, , referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initia & Emp. No				
	9.30 100 dad pain			LIF.	Nerwin	Phone a cological warragement don	o. Clair	N O35			
	11.30	γιο	doll pain	210	back	Opufortable position grow	Jair Joy	Dos			
(67°00)	so de so piro			, ,	C		O In	Noon			
المحطرون	Sp	/	100 pain	1			ON An	Nul			
PAIN SCALES											
(28 weel	PJPPS cs to <u><</u> 38	weeks)	6 or less = Minimal to no 7 • 12 = Mild pain - Provid >12 = Moderate to sever	le comfort me		n					
(38 we	CRIES eks - 2 m	onths)				of gestation. A maximal score of 10 is possible. If the CRIES esic administration is indicated for a score of 6 or higher.	S score is > 4,	-			
	ACC Sca nths - 7 y		0: Relaxed & comfortable	e, 1-3: Mild d	Iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe discomfort / pain / both					
Pain	-Baker F# Rating Se ars - 12 ye	cale	O 2 No Hurts Little Bit	(OO) Hurts Little More	6 Hurts Even More	Numerical Rating So 8 10 Hurts hole Lot None Mild	tale (age more than 1) 5 6 7 8 Moderate	9 10 evere			
Observa	ical care F atlon Tool ator / com	(CPOT)	COMPLIANCE WITH VEN	Absence of m NTILATION (li ubated patier lelaxed, 1 - Te	novements or normal ; ntubated patlents): 0 nts): 0 - Talking on no nse, Rigid, 2 - Very Te	osition, 1 - Protection, 2 - Restlessness / Agitation - Tolerating Ventilator or Movement , 1 - Coughing but tolerating mal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sot ase, Rigid					
Non-pharmacological Interventions Distraction: A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers Cutaneous Stimulation and massage: E - Positioning; F - Rubbing / Massage the skin Thermal Therapies (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy Transcutaneous electrical nerve stimulation (TENS): J - Interferntial therapy Psycho-social therapy/counselling: K - Individual Counseling; L - Family counseling											

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Prince Description of the Mr. BALASUBRAMANI

62/Malc/MHI202381326

27/12/2023/IPH2023002613

Dr.RAJESH.V



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.
l' .		Nopen		7	_		700
31/19/13	ola	No pair	(.	_		© 2.41	Nac 024
7-00	Olw	NO pai	_	1		6004	1024
10.00	0/40	No pain			•	Jesta	7007
2,00	5/18	•				273	News.
\$ 00	9/18					2373	Naca
72.00	elu	p to part	_	<u></u>	·	027	Nac 0024
Jory 11/39	Obo	No poin	1	(- P 24	Nac_ 0024
Por	©Cic	No pour	/				- Nae Joseph

	.,		- Channel	г	<u> </u>				Senior Staff
Date & Time	Pain Score	(dull, achy	Pain Character , sharp, stabbing, shooting, g, referred / radiant pain)	Duration	Location / Site	Interventions		Staff Initial & Emp. No.	Initial & Emp. No.
10.00	0/10		No pain	- ,				Postn	New
1hto	el so	N	10 pcn		(^		SOIN	Nue 1
فحراج		/	vo pein			· .		egan!	Nag-
12-00	ورب		No peur		_		· · · ·	Port !	Nagy
٠				_	PA	IN SCALES			٠.
, (28 week	PIPPS te to ≤ 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	le comfort me		1	,		
(38 wē	CRIES eks - 2 m	onths)				of gestation. A maximal score of 10 is possible. If the CR asic administration is indicated for a score of 6 or higher		r	•
	ACC Sca nths - 7 y		0: Relaxed & comfortable	e, 1-3: Mild d	scomfort, 4-6: Mode	ate discomfort, 7-10: Severe discomfort / pain / both			
Paln	-Baker F/ Rating S ars - 12 ye	cale	O 2 No Hurts Hurt Little Bit	(9) 4 Hurts Little More	6 Hurts Even More	Numerical Rating Numerical Rating 1 2 3 Hurts hole Lot Worst None Mild	Scale (age mo	re than 12	9 10
Observa (ventila	cal care F tion Tool itor / com	(CPOT)	COMPLIANCE WITH VEI	Absence of m NTILATION (II ubated patler lelaxed, 1 - Te	ovements or normal p ntubated patients): 0 nts): 0 - Talking on no nse, Rigid, 2 - Very Te	osition, 1 - Protection, 2 - Restlessness / Agitation Tolerating Ventilator or Movement , 1 - Coughing but tolera mal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, ise, Rigid		· entilator (or)	· · · · · · · · · · · · · · · · · · ·
	harmacol tervention		Cutaneous Stimulation a Thermal Theraples (no lo	i nd massage: inger than 15	E - Positioning; F - Reto 20 minutes): G - Co	Music; D - Physical and mental exercisers bbing / Massage the skin d application; H - Hot application; I - Shortwave diathermy rerntial therapy Psycho-social therapy/counselling: K	- Individual Counse	ling; L - Family	counseling
Pharmac	ological i	nterventio	ns as per doctor's prescrip	tion					

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

Dr.RAJESH.V



MHI/NUR/2022/052



PAI	N R	E-ASSESSMENT	& MC	NITORING	CHART	LENGTHA DIR TRALIMITERI DARIKATARA BADAK	Every heart I	eat counts
Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Inter	ventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
20172H	Plu)	<i>-</i>			024	Nace_
barn	e Cho	No Pain		-			@ @2 7	Naa,
10-20	0/10	No pain	_				John	Naa
					T			

Date & Time	. Pain Score	(dull, achy	ain Character , sharp, stabbing, shooting, , referred / radiant pain)	Duration	Location / Site		Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
·							.:		
	•				 	AIN SCALES	<u> </u>		
(28 week	PIPPS s to <u><</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to seven	de comfort me		n	·		
(38 we	CRIES eks - 2 m	onths)	The CRIES scale is used further pain assessment	for infants >	than or = 38 weeks	of gestation. A maximal sco jesic administration is indica	re of 10 is possible. If the CRIES score is > 4 ted for a score of 6 or higher.	1,	
	ACC Sca		0: Relaxed & comfortable	e, 1-3: Mild di	iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe	e discomfort / pain / both		
Pain	-Baker F/ Rating S ars - 12 y	cale	O 2 No Hurts Little Bit	4 Hurts Little More	6 Hurts Even More	8 10 Hurts Whole Lot Worst	Numerical Rating Scale (age n	7 8	years) 9 10
Observa	cal care f ition Tool itor / com	(CPOT)	COMPLIANCE WITH VEN	Absence of m NTILATION (in ubated patier Relaxed, 1 - Te	novements or normal (Intubated patients): 0 Ints): 0 - Talking on no Inse, Rigid, 2 - Very Te	position, 1 - Protection, 2 - Res - Tolerating Ventilator or Move rmal tone or no sound, 1 - Sigl nse, Rigid	tlessness / Agitation ement , 1 - Coughing but tolerating, 2 - Fighting ning, Moaning, 2 - Crying out, sobbing	ventilator (or)	
	harmacol terventior		Cutaneous Stimulation a Thermal Therapies (no lo	ind massage: inger than 15	E - Positioning; F - R to 20 minutes); G - Co	- Music; D - Physical and men ubbing / Massage the skin old application; H - Hot applica erferntial therapy Psycho-s		seling; L - Family	r counseling
Pharmac	ological l	ntervention	ns as per doctor's prescrip	tion					



62/Male/MHJ202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V





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	igh a score of 1 if (125) in parameter hos. 1 to 9,				(169)	iii parai	Hetel He	·. 10
	Date	27/12	28/12	2				
	Time	14.00	7.00					
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	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)	0	0					
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0					
5	Entire leg swollen (Assess for both legs)	0	0					
6	Localized tenderness along the deep venous system (Assess for both legs)	O	0					
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	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)	<i>_</i> -						
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.	б	0					
	FINAL SCORE	Ð	b					
Low R	lisk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	Con	Low					
	DVT prophylaxis started	☐ Yes ☑ No	∐ Yes ⊟ N୪	☐ Yes ☐ No	□Yes □No	□Yes □No	□Yes □No	□ Yes □ No
	Signature & Emp. No. of RN	180).	13 7a					
	Signature & Emp. No. of Sr. RN	100						
		205	705					



Mr.BALASUBRAMANI
62/Male/MHI202381326
27/12/2023/IPH2023002613
Dr.RAJESH.V



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 (125) in parameter nos. 1 to 9,		- 1		` .			
	Date	Skylos	29 12/2	30/2/	31/2P		29124	
	Time	13'AK	6 26-00	6-00	D.coo	6,00	6.00	
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	Ø	O	b	0	0	0	
2	Bedridden recently >3 days or major surgery within four weeks	4	+1	+1	+1	+1	H	
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	٥	0	b ·	0	0	0	
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	b	0	O	0	Ø	Ø	
5	Entire leg swollen (Assess for both legs)	0_	0	0	0	_0_	Ø	
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	Ø	0	b	0	
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	Ø	D	Ь	0	D	0	
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	Ø	0	Ф	0	0	Ø	
9	Previously documented DVT (Assess for both legs)	O	б	0		10		
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.	8	O	Ф	0	0	0	
	FINAL SCORE	+1	41	+1	4	+1	41	
Low R	lisk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	Mod	mad	Ton	WED	MOD	MaD	
	DVT prophylaxis started	Yes No	√El Yes •	☑ Yes □ No	Ves □ No	∏ Yes □ No	/□Yes □No	□ Yes □ No
	Signature & Emp. No. of RN	W W	101	577	Ø.A	1894 1894),
	Signature & Emp. No. of Sr. RN	$\overline{\Lambda}$	/d	w/	Nus	Noon	120	
		000	000	2017	24	2	V	



Medway Hospitals

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



Mr.BALASUBRAMANI

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

Dr.RAJESH.V





MODIFIED MORSE FALL RISK ASSESSMENT CHART

Mariables	Date	27/12	27 12	2819						
Variables	Time		20.00	``'						
History of falling	No	0_	0	_O_	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	0	0	0	0	0	0	0	0
(≥ 2 medical diagnosis)	Yes	15	1,5	15	15	15	15	15	15	15
Intravenous Therapy /	No	0 /	0	۵.	- 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		6	0/	18	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		9	0	صور	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		6-	9	æ	0	0	0 .	o	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,	No Yes	0 15	0 145	, 0 ,15	0	0	0	0	0	0
anti-hypertensives, hypoglycemics and psychotropics										
Total Score		15	30	20						
Low Risk (0 - 24)		60U	,							
Medium Risk (25 - 44)		·	~			-	-			-
High Risk (45 or above)			W							
Signature & Emp. No. of RN		989	12/12	.S . 97						-
Signature & Emp. No. of Sr. RN		(De)	W.	رُون			-			
		95	24: Low	Risk; 2	5 - 44: N	ledium	Risk; 45	or abo	ve: High	Risk
					* * *		,			

[- 					ſ	1	1		, 	
INTERVENTIONS	Date	27/12	27/2	27/12			<u> </u>		}	,
Tick as per the Risk Score	Time	124.00	20.00							•
Low Risk Interventions (0 - 24)		100	_A/-O(- X-(X-				1	<u> </u>	
Familiarize the patient with the immediate surround	lings			r			ļ	1		
Remind the patient to use call bell before getting ou		 				-			 	
Keep the two side rails in the raised position at all t		\vdash		 		 	 -	 	 	-
all patients regardless of age		. <	/			,	ļ	1		<u> </u>
Keep the call bell, bedside table, water, glasses w	ithin the				-	 	 	 		
patient's easy reach				·		ŀ	ļ			i
Remove excess equipment or furniture to make	a clear			 			 	 		
path	u 0.0u.		·				ŀ		,	
Keep the patient's bed in the low position at all times	sexcept		<u> </u>						 	
during procedure						1	1		···	} .
Teach fall-prevention techniques, such as sitting	up for a									
moment before rising from the bed								ŀ	ŀ	ŀ
Bed wheels should be locked								 	 ` 	
Encourage family participation in the patient's care				7			 · · · · · ·	 	 	
Ensure that floor of the bathroom is dry and not slip		 						 	 	
Review medications for potential side effects t	•	/	٠.			-	 	 	 	-
promote falls			V			Ì		-	1	
Use safety belts during movement in wheelchair		1//				 	<u> </u>	<u> </u>	 	1
The patients are not ambulated by themselves. The	ev are to						 	 	 	
be ambulated only with assistance	· , · · · · · ·	_						· ·	1	
Medium risk interventions (25 - 44)		 	· ·	,	-					
Apply all the low risk interventions	•	'			_		! :	· ·		-
Tie yellow fall risk tag in the bed and Wheel chair / St	tretcher					-	 	 	 	
Make sure that proper transfer precautions are in		<u> </u>					· ·			-
for heavy or debilitated patients in a bed or wheel		l ./				[*,		
on a toilet seat		\ \ \		'		·	j .			
Use restraints and bed monitors as ordered by the o	doctor								1	
Allow the patient to ambulate only with assistance				~					i	
Consider peak effects of the medications that effects	cts level	<u> </u>			_		 -			
of consciousness, gait and elimination when p		/	· 🗸			}	ŀ		ļ	
patient's care	_	~		,		ŀ				
Do not leave patients unattended in diagno	stic or		<i>-</i> ./		-	1				
treatment areas							ŀ			
Accompany the patient while going to bathroom									ļ	
Advice the patient to use grab bars near the toilet, t	oathtub,			-						
and shower									l	}
Make sure the family and other visitors underst	and the	/	. /			Ī .				
restrictions mentioned above		<i>\rangle</i>	· 🗸			'				
High-risk interventions (45 or abovc)		<u> </u>		<u> </u>			<u> </u>	<u> </u>	<u> </u>	
Apply all the low and medium risk interventions] -					1	l .	<u>.</u>	1
Tie red fall risk tag in the bed, wheel chair and stretc	her	, -	-				•		ļ	'
Locate the high-risk patients in a room close to the	nurses'			<u> </u>						
station			·	<u> </u>		L		<u></u>	L	
Answer these patients call bells as quickly as possil	ble									
Provide a commode at bedside (if appropriate)										
Urinal/bedpan should be within easy reach (if appro										
Encourage family members or other visitors to s	tay with						[
them		ļ				<u> </u>	<u> </u>	1		
If appropriate, consider using protection devices	s: safety	:						-		
belts					•	<u> </u>	<u>'</u>			
Signature & Emp. No.	of RN	980) _r	TAR	250	-			1		} ·
Signature & Emp. No. of	<u>`</u>	 / S	000	9 ,				+	 	1
Signature α Emp. No. or	ar UIA	T (1006)		الممكم	Ļ	<u> </u>		<u> </u>	<u> </u>	
		104	- 105	` "				•		

Medway Hospitals®

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



Mr.BALASUBRAMANI

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

Dr.RAJESH.V





MHI/NUR/2022/046

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	28/12/2	28122	29/12	29/12	29/12/2	30/12	30/12/3	30/12	07/12
	Time	13 AF	20.00	4.00	12.00	1.00	8,00	1200	2000	8.#
History of falling	No	1 8	_0_	J8/	0	(O)	٥	10	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	J15_	15	<i>J</i> 5	15	(15)	-15	15	CHS	15
Intravenous Therapy /	No	0	0	0	0	0	10	0_	_ 9/	9/
Heparin Lock / Tubes Insitu	Yes	,20	.20	20	,20	20	20	20	20	20
AMBULATORY AID										ł
None / Bed Rest / Nurse Assist	<u> </u>	,0	-0	0	-0	1	20	0	08	9
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT -			_ ا	/		8	_/		_/	
Normal / Bed Rest / Wheel Chair		9	-0	-0	9	<u>6</u>	J8/	40	8	10
Weak	<u> </u>	10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS	 		<u> </u>							
Oriented to own stability		0	.0	18	D/	(A)	يو ا	سو ا	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS										
Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives,	No	0	0	0	0	0_	0	0	0 /	0
immunosuppresent, anticonvulsants,	Yes	15	-15	15	15	(15)	15	15	15	15
anti-hypertensives, hypoglycemics and psychotropics				~				•	ľ	
Total Score		66	50	50	60	চিচ	36	36	35	35
Low Risk (0 - 24)										
Medium Risk (25 - 44)								/		/
High Risk (45 or above)		-				/		-		-
Signature & Emp. No. of RN	(Saus RA	Core	Note of the	O SA	神部	O PORTO	B it	(C)	Room
Signature & Emp. No. of Sr. RN		d	X	W.			2	Vose 1	NE	1924
		O(197)	24: Lg√	Risk ₄)2	5 - APT: N	/ledium	Risk, 45	or abo	ve: High	Risk

INTERVENTIONS	Date	12/2	28/2	alor	alv	20 h		7/15	.d.	j
Tick as per the Risk Score	Time	3° A	20.00	1.00	1200	21-0g	112	(h)P	200	0.04
Low Birdsham antising (0, 04)		19 11	20,00	-a		Q 1-08	8:40	(Au	/	7.5
Low Risk Interventions (0 - 24) Familiarize the patient with the immediate surround	lings				/		/	, -/		
Remind the patient to use call bell before getting ou								7		
Keep the two side rails in the raised position at all t		/		<u>~</u>						
all patients regardless of age		/		/	/				🖫 /	
Keep the call bell, bedside table, water, glasses w	ithin the			,					1	/
patient's easy reach				/	/				<u></u>	\angle
Remove excess equipment or furniture to make	a clear		/	/					/	. /
path		ļ.~		4	ļ				Y/	
Keep the patient's bed in the low position at all times	s except			/					$ \vee $	
during procedure Teach fall-prevention techniques, such as sitting	un for a	Ť						-	 	
moment before rising from the bed	ар юга	/							100	
Bed wheels should be locked					1				1	
Encourage family participation in the patient's care				/					7	
Ensure that floor of the bathroom is dry and not slip	pery	//						-		
Review medications for potential side effects t	hat can	~		•					/	
promote falls					//	<u> </u>			V/	
Use safety belts during movement in wheelchair						ļ				
The patients are not ambulated by themselves. The	ey are to					}			/	
be ambulated only with assistance							/		V	
Medium risk interventions (25 - 44)	9									
Apply all the low risk interventions Tie yellow fall risk tag in the bed and Wheel chair / S	trotobor							1/	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
Make sure that proper transfer precautions are in								<u> </u>		~
for heavy or debilitated patients in a bed or wheel									/	
on a toilet seat	·	_		/	//				🗸 /	
Use restraints and bed monitors as ordered by the	doctor				1					
Allow the patient to ambulate only with assistance	-	/		/						
Consider peak effects of the medications that effe										
of consciousness, gait and elimination when p	planning				/				V	/
patient's care			_	/						
Do not leave patients unattended in diagno	ostic or				/					
treatment areas Accompany the patient while going to bathroom		_								
Advice the patient to use grab bars near the toilet, I	hathtub					1	/		-/	· /
and shower	oannab,			_	/			_	`	/
Make sure the family and other visitors underst	and the		_				<u> </u>			
restrictions mentioned above							_			
High-risk interventions (45 or abovc)				/	\ <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u>				\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ 	
Apply all the low and medium risk interventions										
Tie red fall risk tag in the bed, wheel chair and stretc				4	/_				1	\angle
Locate the high-risk patients in a room close to the	nurses'			1						
station Answer these patients call bells as quickly as possil	hlo				<u> </u>				1	
Provide a commode at bedside (if appropriate)	Die	NP -	NA		NA	W	<u> </u>		\	-
Urinal/bedpan should be within easy reach (if appropriate)	opriate)	NP	NA	NP.	NA	PVVI			-	
Encourage family members or other visitors to s		l '.'		1 1-					\	
them		NO	74	No	NP	m		Ľ		
If appropriate, consider using protection devices	s: safety				/				/	
belts					/		-65			7
Signature & Emp. No.	of RN	TOR SA	S. P.	K NO P	Will St	350	W TO N	MO IN		0.47
Signature & Emp. No. of	Sr. RN		<u> </u>	X 0X"		N N	N.	0	10	W'y
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(A Unit of United Alliance Healthcare Pvt Ltd)



MI.BALASUBRAMANI

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

Dr.RAJESH.V





MODIFIED MORSE FALL RISK ASSESSMENT CHART

• • • • • • • • • • • • • • • • • • • •	Date	3/(6/2)	2 1/2/2	P11112A	11/22	11/29	211/23			
Variables	Time	14.00	20.00	950	120	20.00	8.00	_	-	
History of falling	No	0	10	10	0/	VO	0	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	18	15	15	15	18	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		0	رمی ا	0	9	₽ Ø⁄	8	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							2			
Normal / Bed Rest / Wheel Chair		0	100	9	0	9	1	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		6	u /	6	0	48/	رسور ا	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	√ 0	0	. 0/	0	0	0	0
immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	Yes	15	d 5	.15	15	15	US	15	15	15
Total Score		50	50	8	60	0	5		}	
Low Risk (0 - 24)										
Medium Risk (25 - 44)	1		~		/					
High Risk (45 or above)					- N	<i>3</i> 86				
Signature & Emp. No. of RN		355	8-52	Boffer	Jun	Soft.) No.	<u> </u>		
Signature & Emp. No. of Sr. RN		Ja's	No.	1900 V	1054	199	125			
		, 0 -	24: Low	Risk; 2	5 - 44: N	ledium	Risk; 45	or abo	ve: High	Risk

INTERVENTIONS Tick as per the Risk Score Low Risk Interventions (0-24) Familiarize the patient with the immediate surroundir Remind the patient to use call bell before getting out on Keep the two side rails in the raised position at all ting all patients regardless of age Keep the call bell, bedside table, water, glasses with patient's easy reach Remove excess equipment or furniture to make a path Keep the patient's bed in the low position at all times of during procedure Teach fall-prevention techniques, such as sitting upmoment 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 slipped Review medications for potential side effects the promote falls Use safety belts during movement in wheelchair The patients are not ambulated by themselves. They be ambulated only with assistance Medium risk interventions Tie yellow fall risk tag in the bed and Wheel chair / Street Make sure that proper transfer precautions are instead for heavy or debilitated patients in a bed or wheel con a toilet seat Use restraints and bed monitors as ordered by the defallow the patient to ambulate only with assistance	ngs of bed nes for hin the	51/ebi	12 12 12 12 12 12 12 12 12 12 12 12 12 1	8.20	PR 120	20.00	2.16.		•	'1
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Familiarize the patient with the immediate surroundir Remind the patient to use call bell before getting out of Keep the two side rails in the raised position at all ting all patients regardless of age. Keep the call bell, bedside table, water, glasses with patient's easy reach. Remove excess equipment or furniture to make a path. Keep the patient's bed in the low position at all times of during procedure. Teach fall-prevention techniques, such as sitting upmoment 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 slipped. Review medications for potential side effects the promote falls. Use safety belts during movement in wheelchair. The patients are not ambulated by themselves. They be ambulated only with assistance. Medium risk interventions (25 - 44). Apply all the low risk interventions. Tie yellow fall risk tag in the bed and Wheel chair / Streward for heavy or debilitated patients in a bed or wheel con a toilet seat. Use restraints and bed monitors as ordered by the definition of the definition of the definition of the patients and bed monitors as ordered by the definitions.	of bed mes for hin the				7	1				
Remind the patient to use call bell before getting out of Keep the two side rails in the raised position at all ting all patients regardless of age. Keep the call bell, bedside table, water, glasses with patient's easy reach. Remove excess equipment or furniture to make a path. Keep the patient's bed in the low position at all times of during procedure. Teach fall-prevention techniques, such as sitting upmoment 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 slipped. Review medications for potential side effects the promote falls. Use safety belts during movement in wheelchair. The patients are not ambulated by themselves. They be ambulated only with assistance. Medium risk interventions. Tie yellow fall risk tag in the bed and Wheel chair / Streward for the proper transfer precautions are instead for heavy or debilitated patients in a bed or wheel con a toilet seat. Use restraints and bed monitors as ordered by the definition of the patients and bed monitors as ordered by the definition of the patients and bed monitors as ordered by the definition of the patients and bed monitors as ordered by the definition and the patients and bed monitors as ordered by the definition of the patients and bed monitors as ordered by the definition and the patients and bed monitors as ordered by the definition and the patients and bed monitors as ordered by the definition and the patients and bed monitors as ordered by the definition and the patients and bed monitors as ordered by the definition and the patients and bed monitors as ordered by the definition and the patients and bed monitors as ordered by the definition and the patients and bed monitors as ordered by the definition and the patients and the patients and the patients and the patients and the patients and the patients and the patients and the patients and the patients and the patients and the patients and the patients and the patients and the	of bed mes for hin the	/		/						
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Remove excess equipment or furniture to make a path Keep the patient's bed in the low position at all times of during procedure Teach fall-prevention techniques, such as sitting upmoment 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 slipped Review medications for potential side effects the promote falls Use safety belts during movement in wheelchair The patients are not ambulated by themselves. They be ambulated only with assistance Medium risk interventions Tie yellow fall risk tag in the bed and Wheel chair / Street Make sure that proper transfer precautions are instead for heavy or debilitated patients in a bed or wheel con a toilet seat Use restraints and bed monitors as ordered by the definitions.	٠.				/	2				
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promote falls Use safety belts during movement in wheelchair The patients are not ambulated by themselves. They be ambulated only with assistance Medium risk interventions (25 - 44) Apply all the low risk interventions Tie yellow fall risk tag in the bed and Wheel chair / Strown Make sure that proper transfer precautions are ins for heavy or debilitated patients in a bed or wheel con a toilet seat Use restraints and bed monitors as ordered by the definition of the safety of the definition of the safety of the definition of the safety of the definition of the safety of the definition of the safety of the definition of the safety of the definition of the safety o	<u> </u>						-	_		
Use safety belts during movement in wheelchair The patients are not ambulated by themselves. They be ambulated only with assistance Medium risk interventions (25 - 44) Apply all the low risk interventions Tie yellow fall risk tag in the bed and Wheel chair / Stre Make sure that proper transfer precautions are ins for heavy or debilitated patients in a bed or wheel c on a toilet seat Use restraints and bed monitors as ordered by the do	at oan			\ /\					'	ĺ
The patients are not ambulated by themselves. They be ambulated only with assistance Medium risk interventions (25 - 44) Apply all the low risk interventions Tie yellow fall risk tag in the bed and Wheel chair / Stro Make sure that proper transfer precautions are ins for heavy or debilitated patients in a bed or wheel con a toilet seat Use restraints and bed monitors as ordered by the do						-				
Medium risk interventions (25 - 44) Apply all the low risk interventions Tie yellow fall risk tag in the bed and Wheel chair / Stromake sure that proper transfer precautions are instead for heavy or debilitated patients in a bed or wheel con a toilet seat Use restraints and bed monitors as ordered by the definition of the seat o	are to		-, /							
Medium risk interventions (25 - 44) Apply all the low risk interventions Tie yellow fall risk tag in the bed and Wheel chair / Stromake sure that proper transfer precautions are instructed for heavy or debilitated patients in a bed or wheel con a toilet seat Use restraints and bed monitors as ordered by the definition of the seat of the sea							/			
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Make sure that proper transfer precautions are ins for heavy or debilitated patients in a bed or wheel c on a toilet seat Use restraints and bed monitors as ordered by the do	etcher		V		/	-				
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on a toilet seat Use restraints and bed monitors as ordered by the do			\checkmark					i		
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			\	1.						
Consider peak effects of the medications that effect	ts level	1								
of consciousness, gait and elimination when pla			11/							
patient's care					'					
Do not leave patients unattended in diagnos	stic or						1			
treatment areas			. - /							
Accompany the patient while going to bathroom									_	
Advice the patient to use grab bars near the toilet, ba	athtub,									
and shower										
Make sure the family and other visitors understan	nd the				_					
restrictions mentioned above						,	· /			
High-risk interventions (45 or abovc)					_					
Apply all the low and medium risk interventions				\sim		L			-	
Tie red fall risk tag in the bed, wheel chair and stretch										
Locate the high-risk patients in a room close to the r	nurses'		<u> </u>	h. /			ار _. با			
station				//			ullet			
Answer these patients call bells as quickly as possibl	le			/	_			,		
Provide a commode at bedside (if appropriate)				/_	/					
Urinal/bedpan should be within easy reach (if approp			_ -							<u> </u>
Encourage family members or other visitors to sta	ay with	/						'		
them					/					
If appropriate, consider using protection devices:	safety		\		,		, /			
belts		$\overline{\langle}$	100 2	7.0.	/ \ \	10 xx	912			
Signature & Emp. No. o	f RN	2537	(% %	CON M	"MARKE	45.0	Bash			<u>L</u>
Signature & Emp. No. of Si		201	·g	25	10	100	100	,		{
	r. RN			. ~ `		· 🕶 · 🥠				







Mr.BALASUBRAMANI

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

Dr.RAJESH.V





PATIENT AND FAMILY EDUCATION RECORD

Assessment To be f	filled	by con	cern	ed d	isci	plines. L	lse k	ey b	elov	ν			1		•
Barriers to	Lea	arning								Plan t	o A	ddr	es	s Factors	
Mone		Vision	/ He	earin	g lin	nitations	•] Use	of Ir	nterp	rete)r	
Limited Reading Abilities		Physic	al b	arrie	rs] Edu	cate	fam	ily		
Religious / Cultural Factors		Langu	age	barr	iers] Sim	pie l	.ang	uag	e	
Congnitive Limitations - unable to		Low m	otiv	atio	n/d	esire to	lear	1] Writ	ten l	nstu	ctic	ons	,
understand and follow directions							-								
Completed By : Date 9 7 12 27im	ne	2	O	<u>)</u>	Vurs	se Signa	ture	:_	Ţ	پہلر	,				
Learning December									,	67					
Learning Record Need		Date	Ι,	Visit		Date	Γ,	/isit	2	Date	Γ,	/isit	3	Signatura	}
Need			<u> </u>	Р		1		P	0	Dute		Р	0	Signature	
Discoo		27/12	<u> -</u>	-	۲	22	L		۲		╠	_	۲	D = 4 = 0	ĺ
Disease			-	<u> </u>	╀	 			H		- -	├	-	Doctor	
Information on		•					١.,	, ,		,				The state of the s	
Disease / Diagnostics			P	∞	V		P	يان	Ľ		ļ	<u> </u>		Yus	711)
☐ Treatment			17	012	V		<u> </u>		<u> </u>			<u> </u>		2500	•
Medications			4	M	<u>↓</u>	2	প	U	ノ	_				Doctor / Nurse	
☐ Information on Safe and															6 -
Effective use of medicines			4	מכו	ot	<u> </u>	P	රුර	J		<u> </u>	<u> </u>		,	,
☐ Information on drug / drug and								i						\bigcap	ڪ
drug / food interactions			12	ÒΩ	1) <u>-</u>	रि	٥ß	J		<u> </u>		_	574	9
☐ Discharge Medications			Ĺ										Ĺ		
Surgical Instructions														Nurse	
Pre - Operative Instructions			Þ	כפ	\bigvee	′	p	01	~				_	100	
Post - Operative Instructions														,	
(Wound / Dressing Care)															
Pain Management														Nurse	
Reporting of pain			P	OD	V		V	NO.	V					1100	
Pain Management	\neg		þ	002	V		P	00		1				1024	
Safe and effective use of medica	1		,				`							Doctor / Nurse	
Equipment (if required)]				L										
Name of Equipment	\neg														
Rehabilitation Techniques				1											Ι.

Nutritional Guidance Diet Instruction for patients at Nutritional risk Diet advice for home Discharge Planning Self care Follow up Reporting Concerns Immunizations Parenting education Others Risk Factor Reduction Smoking Cessation Weight Control Exercise		L ()	P	0 0 0		7 5 7				,	P 옳	• •	Dietician
Diet Instruction for patients at Nutritional risk Diet advice for home Discharge Planning Self care Follow up Reporting Concerns Immunizations Parenting education Others Risk Factor Reduction Smoking Cessation Weight Control		0 -	\$ 1	0 1		⊢∸	1 311					9	Enio California de Jos
Nutritional risk Diet advice for home Discharge Planning Self care Follow up Reporting Concerns Immunizations Parenting education Others Risk Factor Reduction Smoking Cessation Weight Control		0	2	0		⊢∸						Í	£ 10
□ Diet advice for home Discharge Planning □ Self care □ Follow up □ Reporting Concerns Immunizations □ Parenting education □ Others Risk Factor Reduction □ Smoking Cessation □ Weight Control		[] d	3	0 1 1		⊢∸	<u> </u>) (-	<u>- </u>	3111	<i>9</i>	
Discharge Planning Self care Follow up Reporting Concerns Immunizations Parenting education Others Risk Factor Reduction Smoking Cessation Weight Control						dim						H	Nurse
Self care Follow up Reporting Concerns Immunizations Parenting education Others Risk Factor Reduction Smoking Cessation Weight Control												li	
Follow up Reporting Concerns Immunizations Parenting education Others Risk Factor Reduction Smoking Cessation Weight Control													
Reporting Concerns Immunizations Parenting education Others Risk Factor Reduction Smoking Cessation Weight Control													
Immunizations Parenting education Others Risk Factor Reduction Smoking Cessation Weight Control												Ц	
Others Risk Factor Reduction Smoking Cessation Weight Control													
Risk Factor Reduction Smoking Cessation Weight Control													
☐ Smoking Cessation ☐ Weight Control	f											H	
Weight Control	4											H	
<u> </u>												П	Doctor
												Н	
□ Exercise ,												П	
Hypertension	i	Г										П	
Other Risks	<u> </u>											П	
•													
Reports Given :		<u>, </u>											
Given Pendin	g / I	A							Giver	1	Per	ndir	ng NA
Discharge Summary	-		1	Diet	Advice			-		_			
ECG Report	__		_ (CT S	Scan Re	port	t						
Doppler Report	_ 7		_ (CT S	Scan Fil	m							
X-Ray Report	/		6	ECH	O Repo	ort				_			
V Dou Film		\setminus			asound		ort	•					
		_			Other F			-					
Compact Disk			← ′	чпу	* 11 (162F)								

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Mr.BALASUBRAMANI

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

Dr.RAJESH.V





PATIENT AND FAMILY EDUCATION RECORD

Barriers to	Learning	3							Plan t	οА	ddr	es	s Factors		
None [Visio	n / He	arin	g lin	nitations	;			Use	of Ir	iterp	rete)r		
Limited Reading Abilities	Phys	ical b	arrie	rs			,		Î Edu	cate	fam	ily			
Religious / Cultural Factors	Lang	uage	barri	ers				Ų]Sim	ple L	.ang	uag	e		
Congnitive Limitations - unable to	Low	notiv	ation	1 / de	esire to	learr	1		Writ	ten l	nstu	ctic	ns		
understand and follow directions				_							_				
Completed By : Date 23 Time	- 18 <i>E</i>	0		lurs	e Signa	ture	:	*	A DE	M3	100	f 4			
_earning Record	_								1		•				
Need	Date	Ι,	Visit	1	Date	\ \	/isit	2	Date	<u> </u>	/isit	3	Signature		
	role?	ᅡ	Р	О	09/12	L	Р	0	30/12	╏	Р	О	Oignatu.		
	20//	+	-		OX 1112	_		-	0-[1-	Doctor					
Information on		\dagger	┢	\vdash			\vdash			1,60					
Disease / Diagnostics			OD	$ _{\scriptscriptstyle V}$		0	~	/		P OF M			190		
Treatment						7	Q	<u> </u>		7	- 134>				
Medications			0D 10D]			\vdash	H			Doctor / Nurse				
Information on Safe and		+>	ra v	۲		_		\vdash		17	QĒ	J	(d)		
Effective use of medicines		-	┞-	ļ.				-							
☐ Information on drug / drug and	-	╁	╁					\vdash		┢					
drug / food interactions]	-	├				<u> </u>	_			Ì				
Discharge Medications	 	†							_	-					
Surgical Instructions		+	\vdash	\vdash			\vdash	-		-			Nurse		
Pre - Operative Instructions	_	Τ_		-		_						T			
Post - Operative Instructions		\dagger		T			\vdash			_	-				
(Wound / Dressing Care)		10	DD.	l/		S	ට	. /	•		D	vi			
Pain Management			00				3 6			9′	ر ا	η,	Nurse/		
Reporting of pain	_	_	00							6	~~~ ~~~	u,	Doin!		
Pain Management		T	h	V			6 6	レ					THE PERSON NAMED IN		
Safe and effective use of medical		\prod_{i}		ľ				Doctor / Nurse							
Equipment (if required)		413	pp.	V		P	OP	ν							
Name of Equipment		p/								++++					
Rehabilitation Techniques		19/5	OV	V		0	00	V							

1







Mr.BALASUBRAMANI

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

Dr.RAJESH.V





Every heart beat counts

PATIENT AND FAMILY EDUCATION RECORD

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To be filled by concerned disciplines. Use key below Barriers to Learning Plan to Address Factors																	
Barriers to	Lea	arning								Plan t	o A	ddr	es	s Factors			
None		Vision	/ He	arin	g lin	nitations	;		Γ] Use	of lr	nterp	rete) -			
Limited Reading Abilities		Physic	al b	arrie	rs				L] Edu	cate	fam	ily				
Religious / Cultural Factors		Langu	age	barri	iers] Sim	ple 1	ang	uag	e			
Congnitive Limitations - unable to		Low m	otiv	ation	1 / d	esire to	lear	n] Writ	ten l	nstu	ctic	ns			
understand and follow directions																	
Completed By : Date 31/12/13 Tim	ie	8.94	>	N	lurs	e Signa	ture	::_	لح	Pavil	501 C	Đ_	_	}			
Learning Record										-							
Need		Date	Ī	/isit	:1	Date	,	Visit	2	Date	,	/isit	3	Signature			
		2/12/12	L	Р	0	1/12/2	L	Р	0	211/9	7 ₁₂	Р	0	-			
Disease		" "		Г	Г		Г	 		/* (Doctor			
☐ Information on														1/80-			
Disease / Diagnostics			P	20	∤⁄ ∣		p	∂S	D 80 V 12455								
☐ Treatment													1347				
Medications			p	30 Y	V		D	200	J		P	26	J	Doctor / Nurse			
Information on Safe and	-																
Effective use of medicines			B	σŋ	V		R	ക	J		D	ঞ	~	Naa			
☐ Information on drug / drug and			0				U				V			024			
drug / food interactions		_		L													
☐ Discharge Medications																	
Surgical Instructions														Nurse			
Pre - Operative Instructions			RO	23	و		D	æ	V		Ъ	<u>२</u> ०	V	Oal n			
Post - Operative Instructions											y						
(Wound / Dressing Care)			P	ઝ	\checkmark		B	20	V		ρ	8	V				
Pain Management							Nurse										
Reporting of pain	Doby Bov Bov Boln									alln							
Patin Management			<i>A</i>	9	V		B	20	<		- 1	8	>				
Safe and effective use of medical														Doctor / Nurse			
Equipment (if required)]			Ш												
Name of Equipment						1											
Rehabilitation Techniques																	

Need	Date	\	/isit	1	Date	·	/isit	2	Date	,	Visit	t 3	Signature
٠.	9 1 12	-	P	0	91/10	1	Р	0	2/1	ī	Р	О	
Nutritional Guidance		P							- 1.				Dietician
Diet Instruction for patients at Nutritienal risk		P	00	V		P	OΡ	ν		b	en	\frac{1}{2}	aria Califorine John
Diet advice for home		F	_	-		-	_			7	-	H	Nurse Nurse
Discharge Planning													
Self care													
Follow up													
Reporting Concerns Immunizations													
Parenting education												П	
Others										ļ			
Risk Factor Reduction												Ħ	
Smoking Cessation												П	Doctor
☐ Weight Control											T	П	
☐ Exercise												П	
Hypertension ,					<u>.</u>								
Other Risks	pri .	·			·.'								
OUTCOME (O) - RD - Return Demonst Written Material given and explained (V-1	/erb	oaliz	zeď Uno	ders	stand	ding	-				
Reports Given :		,					_		_	_			
Given Pendin	g I	NA							Giver	า	Pe	ndir	ng NA
Discharge Summary			_ [Diet	Advice								
ECG Report					Scan Re	_	t			—			
Doppler Report		<u> </u>	_ (CT S	Scan Fil	m							[
X-Ray Report		/	_	ECH	IO Repo	ort				<u>_</u>			
X-Ray Film			_ '	Jitra	asound	Rep	ort						
Compact Disk			_ /	4ny	Other F	Repo	ort						
Name of Attendant / Patient : 10 - 13	A) 144	ER.	Arc	714	M.		Sig	nati	ure :				Sprin

C- Nalin

Name of Discharge Nurse

Signature :



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

Mr.BALASUBRAMANI

62/Malc/MHI202381326

Name 27/12/2023/IPH2023002613 : UHID

DOB: Dr.RAJESH.V

DOA:

Consu.....



IN-HOUSE TRANSFER FORM

Par	t A (to be filled by Nu	rses)					-	-
Dat	e of Transfer: 30(12	ევ Time: <u> ე</u>	<u>(√O</u> O Tra	ansferred	from: <u>JD</u> .	<u></u>	114	
Dia	gnosis: CAD -7	VD		-			<u>-</u>	
Vita	I Signs: Temp: 100.9 (°F) Pulse / HR:	96	(beats/m	nin) BP: <u>[[</u> 5	ろ9(水(n)mHg) Respi	iration:_) & (breaths/min)
Par	B (to be filled by Ph	ysicians) p	ny Critic	al Investig	ations:	-		
	Check for			Tran	sferring Docto	or		Receiving Doctor
Resp	piratory (Breath sounds)	Clear] Crepitat	ion 🔲 R	honchi 🔲 O	thers:	[Yes No
Abde	omen	Soft	Tender		istended 0	thers:		Yes No
Hear	t Sound	Normal [Feeble	Loud	Others:			Yes No
CNS	-	Consciou	ıs 🗌 Or	iented	GCS Sco	re:	_	Yes No
	Surgical Patients plicable)	Surgical Site;	Heal	thy S	oakage O	thers:		Yes No
		Preser	nt Medic	ation (for	Medication R	econciliation)		
S. No.	Current Medic	ation	Dose	Route	Frequency	Date & Time of last dose		continued during lospital stay
]	THR FEUGERN	DE	Homor	Plo	1-1-0	30/2/30 8.00	Z	∐Yes □ No
١,	THB SPIRANDA		Smrt	Plo	1-1-0	30 12 23 07 10.30	عر	Í Yes □ No
3,	TAB. REPLEX	FORTE	MAB	plo	1-0-0	30/12/23 0/8:05	_ &	Í Yes □ No
للا	Syp. Sucra	FATE	lomi	Plo	1-1-1	20/12/23 at 7.30		No
2	NEB. LEVO	LIN	<u>0-63m</u>	HVE	or6thly.	30/12/22 0/7.30	J	Yes 🗆 No
6	TAB. CLAPILET	t Aspren	4547	Plo	0-1-0	29/12/23at 1400	1	ÍYes □ No
7,	TAB - ATDRUI	-VITHID-	MOH .	Plo	10-0-1	29/12/23 08 21:00	~	Yes □ No
8,	TAB. PARA	CETAMOL	P2010	ı plo	1-1-1	30/12/23 at 8.05		Yes □ No
٩,	Syp. Drem	AFFIN Fly	ismi	plo	D-b-1	29/12/23 of 21:00		Yes □ No
10,	78B. DILZ	Em	30mpt	plo	1-1-1	30(12/230) 8.00		1 Yes □ No
11,	TAB - BETH	Loc	5-2Jup	c plo	1-0-1	30/12/23 at 10.0	, ,,,	Yes □ No
12	TAB - PRAGE	NIAR	#5mon	plo	1-0-1	29/12/23/ 21.61	, [] Yes □ No
	<u> </u>] Yes □ No
	·] Yes □ No
] Yes □ No

Additional Det	tails (if any):						
Patient Condit	tion:	Stable	Sick-need urgent care	Othe	ers:	,		
	Sign	l. /	Name		Reg. No.	Date		Time
Transferring Doctor		*/	Dr. mavoga		112 2 36	30	12 23	12.00
Receiving Doctor	7	-80	Do. h. Arusuy a)	134559	30	12/83	12:10
Part C (to be f	illed l	by Nurses)	V					
Check for			Transferring Nu	rse			Receivi	ng Nurse
Drains		Chest A	bdominal Others:	L			Yes	∏ No
Respiratory		Air Way Type: Oxygen Therapy	/ =	Others	s:Rate:N;li/m	_ in	✓ Yes	☐ No
NG Tube / Oral		Yes No	For Feeding Gastric Suc	tion [Fluid Restriction	-	✓ Yes	∏ No
Foley's Catheter		Yes No					Yes	☐ No
Intravenous Acc	ess	Peripheral Lir	ne Central Venous Line C	Others:			Yes	∏ No
Pressure Injury		Yes Mo	If Yes, give details:				Yes	□ No
Score		Fall Risk: 35	WELLS: NEWS / PEW	/S:			Yes	No No
Patient Belongin	ngs	Yes No	If Yes, give details:			· , · ·	Yes	. ⊡ No
Handover Detail	s	l .	inistration Record explained:	Yes [No	,	Yes	No l
Patient Attendar	nt ,	Yes No	If No, give details:		11.1	· ,	Yes	□ No
Additional De	tails (if any):				· · · ·		· · · ·
				; ;		, ,		
						· · ·		
			,		· · . · . · . · . · . · . · . · . ·		1	~
				•		•	. 1 i	
				•		· : ,		,
	Sign		Name	ŧ	Emp. No. /	Date		Time
Transferring Nurse		au'	GOND TLOCAME!	β	00.7A	301	12/13	(2 - 00
Receiving Nurse	7	R	painthra		0072	20/1	2123	1210



Mr.BALASUBRAMANI

62/Mule/MHI202381326

27/12/2023/IPH2023002613

Dr.RAJESH.V



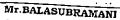


Inter Disciplinary Team Rounds (IDTR) Checklist

Jan

Date: 9 = 12 23	Time:	13.0) O·				
Checklist	Yes	No	NA	Ac	ction / Remarks	-	
MEDICAL							
Daily Consultant Visit							<u>_</u> :
Plan of care discussed							
Discharge Planning	X	·			_		
Others if any	X						
NURSING							
Safety Precautions Ensured	/			<u>-</u>	_		
Care of Lines and Tubes	1						
Infection Control Measures	1						
Skin Care					_		
Response to assistance							
Others if any	X						
DIETICIAN				,			
Diet Adequate							
Special Request							
PHYSIOTHERAPIST							
Available for Assistance for Activities of Daily Living) 				
Others if any							
PATIENT CARE SERVICES							
Room Cleaning satisfactory		_					
Room Amenities Adequate			_	-			
Billing Update available							
Non-Availability of any service							
Spiritual Needs (if yes specify							
Others if any			•		-		
		Ir	iter Dis	sciplinary Team Members		_	
	Signatur			Name	Reg. / Emp. No.	Date	Time
Doctor	Ela	1		Dr. Cri flango	179044	cdalts	13.00
Nursing Staff	<u></u>	Y		B-vanisa	olar	22/12/25	12.00
Dietician		My	<u> </u>	Maria Catherine John	يدره ۲	33/14	<u>_131∞</u>
Physiotherapist		PI		Jamanathan P	0260	28/12/23	المحتم
Patient Care Service Staff						l	





62/Malc/MHI202381326

27/12/2023/IPH2023002613

Dr.RAJESH.V





FAMILY COUNSELLING FORM

CONSU		DI RAIGO	DIAGNOSIS AND - TVD		-	
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
3/12/3		Son Service Services	policy.	l	B. Jm	# 8- U223
2a/12/23	OBUS OFA	Solowood Solowood	explained about the ganeral condition, Abed of Ico Oblay and Medicinal Olypports. Virolators policy explained.	1	Blockin	(1227)



The way to better health (A Unit of United Alliance Healthcare Pvt Ltd) Patient Details (Affix Label here)

Medway

Patient Details (ATIX Laber Troit)

Name: NPA · BAL ASUBRAMAN / Institute

UHID: 202381376

DOB: Sex: 20230020 Every heart beat counts

WOUND ASSESSMENT CHART

DATE	2/1/23						
SITE OF WOUND							
CHEST							
LEG L/R							
ABDOMEN							
SACRAL REGION						 ļ	
HEEL							
OTHERS						 -	
SIZE OF THE WOUND						 	
SUPERFICIAL / DEEP IN NATURE							
PRESSURE Specify system used :							
RISK FACTORS Specify system used :	COM	HTN	Age	Obesity	_		
WOUND TISSUE TYPE(S) PRESENT							
necrotic							
slough							
slough undermining							
slough undermining granulation				0 0 0			
slough undermining granulation overgranulation		: : : : : : : : : : : : : : : : : : :		0 0 0			
slough undermining granulation overgranulation epithelialisation				0 0 0 0			
slough undermining granulation overgranulation epithelialisation other		: : : : : : : : : : : : : : : : : : :		0 0 0			
slough undermining granulation overgranulation epithelialisation							
slough undermining granulation overgranulation epithelialisation other SURROUNDING SKIN TISSUE TYPE(S) macerated							0 0 0 0 0 0
slough undermining granulation overgranulation epithelialisation other SURROUNDING SKIN TISSUE TYPE(S)							
slough undermining granulation overgranulation epithelialisation other SURROUNDING SKIN TISSUE TYPE(S) macerated erythema							0 0 0 0 0 0
slough undermining granulation overgranulation epithelialisation other SURROUNDING SKIN TISSUE TYPE(S) macerated erythema oedematous							
slough undermining granulation overgranulation epithelialisation other SURROUNDING SKIN TISSUE TYPE(S) macerated erythema oedematous cellulitis							
slough undermining granulation overgranulation epithelialisation other SURROUNDING SKIN TISSUE TYPE(S) macerated erythema oedematous cellulitis blistered							

WOUND ASSESSMENT CHART

EXUDATE AMOUNT	2/1/23							
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								
(nil) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (max)								
INFECTION SUSPECTED*								
SWAB SENT								
ANTIBIOTIC THERAPHY								
BLOOD GLUCOSE / URINE ANALYSIS		. 🗆						
PATIENT / CARER TO DO DRESSING								
SIGNATURE	Rollin	_						
*SIGNS & SYMPTOMS OF WOUND INFECT	g 1 2 3	**************************************	PECT WOU	ND INFECTI	ON IF			
licalised pain pus erythema offensive	· · · · · · · · · · · · · · · · · · ·	• gra	inulation tiss glie bridge o our increas	ue bleeds e f epithelium	asily •	***	17	inticipated







Every heart beat counts

VIP SCALE (VISUAL INFUSION PHLEBITIS)

Mr.BALASUBRAMANI

AGE / SEX:

PATIENT NAME: 62/Malc/MH1202381326

27/12/2023/IPH2023002613

Dr.RAJESH.V IP No. / UHID No

Ward / Bed No. Alw - 3.

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S/N EMP No.
0.8/12/23	13'A5	(R) Cuby b	OF			MOSIGN OF PHOE	eriis Quino
- · · · ·	D8.00	Rf cubita	0/5	10 line palent	l	No sign y phlese	tu Vikyulog
	200	(Publica)	05	Wline pedoud	Lund	No synd of physe on	in Openion
30/13/23	12.00	(Doubital	0/5	IV live patout	Bonest	NO SIGNS OF PHIOSI	is glave loot
	21-00	िटा का उस	0/5	PATENT	FLUGHED	OBSERVATION	S.E.
30/12/23	8,00	Quebital	05	IN line patrol	4 (m)	MOSIGNS OF PHICER	ics Spulliota
30/1475	(h)	Copyler	<i>ઇ</i>	En Ineputart	Theylad		OR PANN
	21.00	lunital	015	Dy his paros	Polled	~	(RA)
ליצו	8.00	abjal	0/5	- pa-lex	Jlus Lad		Polin
3/12/	14.00	cupital	0/5	protect	Hugh		173
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(A Unit of United Alliance Healthcare Pvt Ltd)

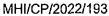
Mr.BALASUBRAMANI 62/Male/MHI202381326

Date of Reg : 15/12/2023 12:33 PM





Date of Admission: 15 23 Time: 11.80 Speciality: ______ Nationality: _____ Name: NOR PALASOBRANANIEX: 63/19 UHID: DOB: Consultant: Return to ER within 72 hours: 🗌 Yes 🔲 🎖 👉 👚 Triage 🔲 1 🔲 2 🔲 3 🔲 4 🔲 5 🔛 Non Trauma 🔲 Trauma MLC No.: _____ Allergies: ☐ No☐ Yes (if yes, specify): DONINNICAD - SIRM IN 2019 (? UNSATELL ANGIND !? SAT Clinical Diagnosis: Chief Complaints: CURRETTERN DISCOMPANY / BURRYTHURSHIKKS CH REXPENSED X 1/1-Past Clinical History: SpO,% GCS Resp. Rate/min. Pain Score VITALS BP (mmHg) PR/min. Temp °F 94.2 82/mt 0110 . 20 13/15 At Admission cslyn 2646 At Discharge 82 ලා %. SYSTEMIC EXAMINATIONS TREATMENT GIVEN Head & Neck: VIANS & MANGE Chest: MINIMPL ATTA COUNTY 624 - NO PENTE CHYMNES CVS: 56 EUro - FF-62% NO IWMA Sum Abdomen: alle DR. SIVASCHANAMICANIATION C SAM CNS: Extremities: Investigations Advised (if any): Discharge Advice: CAMPAUR PRACUME MADICATIONAL 70 DO CASHPAREN IN - IN PORT TIMET AND CANTPORGE RIN IX IN RU AGAP. In case of the following symptoms, kindly contact EMERGENCY Tel: 044 - 2473 4455 ☐ Fever > 101°F, Rigor or Chills Other Symptoms: Pain, Headache and Vomiting Discharge from wound Follow up advice: Condition at time of discharge: Stable Critically III ☐ Comatosed Dead on Arrival Date of Discharge:_ Time of Discharge:__ _ Type of Discharge: ☐ Normal ☐ Referred ☐ LAMA Signature Name Reg. No. Date Time Dr. Anish Nelson Dr. Anish Nelson Λ $\lambda \lambda \nu_{\nu}$ Doctor 15/12/20 Reg. No: 88434 2.50 Reg. No: 88434 Relationship 💯 🗗 Patient / Attendant BALASUBRAMINT







Every heart beat counts

Mr.BALASUBRAMANI 62/Male/MHI202381326

27/12/2023/IPH2023002613

Dr.RAJESH.V

HOME MEDICATION USAGE FORM

Allergies: NKJA Unstable anglina / CAD-TVD/T2DM/SHTN Diagnosis: Batch No. Medication name brought Temp. Prescribed drug name Dose & Expiry Freq. Qty. by Patient/ Attender date 5NZ1405 7/24 5/50ma Dytox وسلع 1-00 4 T. Dytor plus BRU 2140A 125°C 20 mg P. Atorvas 0-0-1 16 - Atoovas COT 1,114 8/25 225°C 10 1500mia T. Methyloob alamin 0-0-1 T. Groben Grober 300m 0-1-0 1. T. Newrobion foste 323483901 Neurobion forte 1 tal 0-0-1 125C 11 1125 T. Isonti To 6316 625°C T. Trongt 0-07 13 5ma T. Ni Koran To Comet T. Cornet 500mal 1-0-1 17 30 ho unt 94 10 04 8 25+15-Inj. wasulin · Wosulin 501 JAA 23033 3/25 T. Janunet T. Janunet 15 0-1-0 T. Angiplat Angriplat 1-0-1 bont 52000 Emp. No. Date & Time Signature Name Korr 27/n/2 Doctor 27/12/23 Clinical V. Padmapriya 0229 16,11 **Pharmacist**

This is to certify that, I take full responsibility of the quality and potency of the medications that I have brought to the hospital. Medications that I have got are stored with proper medication storage recommendation given by the manufacturer (Room temperature (below 25°C) or Fridge temperature (2°-8°C)). Any Adverse effects that is caused or effects that affects my recovery due to improper storage condition of medications that I have got from home, will be under my responsibility. I am aware that several medications that are available in Indian and International market are spurious and bogus which can cause harm to my health. I assure that Medway Hospitals or its employees will not be held responsible for any outcome/ results in the future.

	Signature/ Thumb impression	Name	Date	Time
Patient			1 1 1 1	
Guardian	13hu/==	Bhuvanes wari (Daughtet) (Name and Relationship with the Patient)	27/12/23	16:15

Reason for Guardian consent:

	Signature/ Thumb impression	Name	Date	Time
Assigned Staff	P	A. Nardhini	27/12/23	16.15

Clare Company of the and the company of the company





Mr.BALASUBRAMANI

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

Dr.RAJESH.V



MHI/PHARM/2022/028



Every heart beat counts

MEDICATION ADMINISTRATION RECORD

Drug	Chart:	†of_				Heig	ht (cms):	168cm	Weigh	t (kg): <u>7</u> 8	200
		KNOWN MI	EDICINE AL	LERGIE	S (if NC	ONE is c	onfirmed,	write NKDA ir	box 1)		_
Drug De	etails			Descrip	otion of	Aliergy			Doct	or's Sign: 🐧	tyo
		- W	CDA_						Ì	2,7C1 ::	ממיחת פי
ł	_						<u>- '' , '' </u>	_	Reg.	No. 179	047
D	OCTO	R INSTRUCTIO	vs					TAFF INSTRUC	CTIONS		
1. Use generic name when prescribing drug 2. Write in BLOCK LETTERS, clearly and legibly 3. Sign and enter MCI registration no. or apply seal 4. No prescription should be altered / overwritten 5. Use 24-hour format when writing time 1. C					in-charge w prescrip standard ard Timing : 06:00hrs, rs, 17:00hr	should ve ption, follow timings gs: Q24hrly 14:00hrs, 2 rs, 23:00hrs	w the timing: : 10:00hrs, Q 22:00hrs or 0 s, Q4hrly: 02:	art on daily basis s of doctor's presc 12hrly: 10:00hrs, 22 9:00hrs, 14:00hrs, 2 00hrs, 06:00hrs, 10:	2:00hrs or 0 11:00hrs, Q6	6:00hrs, 18:00h Shrly: 05:00hrs,	nrs,
	T I		Stat / C	Once O	nly / P	remed	ication				
Date	Time		Drug		Dose	Route	Sign.	Doctor Reg. No.	Sign.	Administere Emp. No.	Time
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REGULAR PRESCRIF	PTIONS I	Date →	To be	filled b	y Nurs	ing Sta	ff only.	Sign a	nd time	given
To be filled in by Doctor		Time ↓	24/12	28/18						,
DRUG NAME										
T. Dyto plus	T	<u> </u>		100						
Dose Route	Frequency	8:00 an		Tho						
Dr. Sign & Reg. No. / Seal	Start Date & Time	<u> </u>			 			 	 	
E7:	Stop Date & Time							<u> </u>		
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DRUG NAME 7- we try ud	radanin									
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Dr. Sign & Reg. No. / Seal	Start Date & Time									
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Area In-charge		1						 -		
Nurse Signature:				100 V	S					

, ,			Date →	To be	filled b	ov Nure	ing Sta	iff only	Sign a	nd time	niver
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Area In-charge Nurse Signature	e: 			100 J	100	k K					

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NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
<u> </u>	Morning					Morning			
	Evening					Evening			
四年	Night	A. Mandhein	0170	A.	-	Night			
28 1212	840	A. Nanthini	0140	A		Morning			
1	Evening					Evening			
	Night					Night			
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-	Evening				_	Evening			
	Night				-	Night			
	Morning					Morning	<u></u>		
	Evening					Evening			
	Night				_	Night			





Mr.BALASUBRAMANI

62/Malc/MHI202381326 27/12/2023/IPH2023002613

Or.RAJESH.V



MHI/PHARM/2022/028



Every heart beat counts

MEDICATION ADMINISTRATION RECORD

Drug	Chart:	Of KNOWN MEDICINE AL	LERGIE	S (if NO			_L5&cm , write NKDA ir		t (kg): <u>국</u> 용	ig_
Drug De	tails		Descrip	otion of	Alleray			Doct	or's Sign:	
		NKDA					¥ 353 	Nam	e: DR PRA SBYAKOHI No. 1122!	
			,							
D	OCTO	RINSTRUCTIONS	l		NU	RSING S	TAFF INSTRUC	CTIONS		
1. Use ge 2. Write ir 3. Sign ar 4. No pre	neric nar BLOCK nd enter	R INSTRUCTIONS me when prescribing drug LETTERS, clearly and legibly MCI registration no: or apply seal should be altered / overwritten mat when writing time	2. Núrse 3. For ne follow 4. Standa Q8hrly:	in-charge w prescri standard ard Timino : 06:00hrs,	every sec should ve otion, follor timings gs: Q24hrly 14:00hrs, 2	tion to avoid rify drug cha w the timing to 10:00hrs, C 22:00hrs or 0		ription on 2:00hrs or 0 1:00hrs, Q	Day 1 only, and 16:00hrs, 18:00h 6hrly: 05:00hrs,	rs,
1. Use ge 2. Write ir 3. Sign ar 4. No pre	neric nar BLOCK nd enter	ne when prescribing drug LETTERS, clearly and legibly MCI registration no: or apply seal should be altered / overwritten mat when writing time	2. Núrse 3. For ne follow 4. Standa Q8hrly 11:00h	in-charge w prescrip standard ard Timing 06:00hrs, rs, 17:00hr	every sec should ve otion, follor timings gs: Q24hrly 14:00hrs, 2 rs, 23:00hrs	tion to avoid rify drug cha w the timing to 10:00hrs, C 22:00hrs or 0	omissions art on daily basis s of doctor's presc 112hrly: 10:00hrs, 22 9:00hrs, 14:00hrs, 2 00hrs, 06:00hrs, 10:	ription on 2:00hrs or 0 1:00hrs, Q	Day 1 only, and 16:00hrs, 18:00h 6hrly: 05:00hrs,	rs,
1. Use ge 2. Write ir 3. Sign ar 4. No pre 5. Use 24	eneric man in BLOCK and enter scription scription	ne when prescribing drug LETTERS, clearly and legibly MCI registration no. or apply seal should be altered / overwritten mat when writing time Stat / C	2. Núrse 3. For ne follow 4. Standa Q8hrly 11:00h	in-charge w prescrip standard ard Timing c 06:00hrs, rs, 17:00hr	every sec should ve otion, follor timings gs: Q24hrly 14:00hrs, 2 rs, 23:00hrs	tion to avoic rify drug cha w the timing :: 10:00hrs, C 22:00hrs or 0 s, G4hrly: 02:	omissions art on daily basis s of doctor's presc 112hrly: 10:00hrs, 22 9:00hrs, 14:00hrs, 2 00hrs, 06:00hrs, 10:	ription on 2:00hrs or 0 11:00hrs, Q 00hrs, 14:0	Day 1 only, and 16:00hrs, 18:00h 6hrly: 05:00hrs,	rs, 22:00hrs
1. Use ge 2. Write ir 3. Sign ar 4. No pre	neric nar BLOCK nd enter	ne when prescribing drug LETTERS, clearly and legibly MCI registration no: or apply seal should be altered / overwritten mat when writing time	2. Núrse 3. For ne follow 4. Standa Q8hrly 11:00h	in-charge w prescrip standard ard Timing 06:00hrs, rs, 17:00hr	every sec should ve otion, follor timings gs: Q24hrly 14:00hrs, 2 rs, 23:00hrs	tion to avoic rify drug cha w the timing :: 10:00hrs, C 22:00hrs or 0 s, G4hrly: 02:	omissions art on daily basis s of doctor's presc at2hrly: 10:00hrs, 22 9:00hrs, 14:00hrs, 2 00hrs, 06:00hrs, 10:	ription on 2:00hrs or 0 11:00hrs, Q 00hrs, 14:0	Day 1 only, and 16:00hrs, 18:00h 6hrly: 05:00hrs, 18:00hrs,	rs, 22:00hrs

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28/12/23	<u>23</u> .45		dong	ļ	4	112236	V.pm	اما	23.45
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To be filled by Nursing Staff only. Sign and time given Date -**REGULAR PRESCRIPTIONS** To be filled in by Doctors only Time **↓ DRUG NAME** 7.00 THI PARACETATAOL Dose Route Frequency Clinical Pharmodist O Both 1200 PV Dr. Sign PARTEEN DEVARDINAR Start Date & Time 16.00 28/12/23@15m Reg. No:112236 Stop Date & Time Ø 33.00 29/12/23 at 10.00 Additional Info: **DRUG NAME** 07.30 SUP SUCRALEATE SUSPENSION Clinical Pharmacist Route Frequency Dose Plo -1lone Start Date & Time
28/12/23 20.00 Dr. Sign & Reg. No. / Seal 808 13.30 Dr. PRAVEEN JEYAKUMAR Reg. No: 112236 Stop Date & Time 19.30 Additional Info: DRUG NAME A.00 NEB. LEVOSDIBUTAMOL Route Frequency Dose 0.3 Gentical Phothistical Medical Medical Institute 10.00 Q B+A Forli 0.63 mg DNH Dr. Sign & REPEN JEYAKUMAR Start Date & Time 28/12/03 at 1600 16.00 Reg. No:112236 Stop Date & Time 99.00 Additional Info: **DRUG NAME** 8,00 TAB. FRUSEMIDE Clinical Pharmacist Medway Hearl Institute Route Dose Frequency Dac Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR 1-1-0 Start Date & Time 8.00 Q 16.00 Reg. No:112236 Stop Date & Time Ø 31/12/23@9:00 Additional Info: **DRUG NAME** TAR SPIRAMOLACIONE 10.20 Route Dose Frequency 1350 10,00 1-1-0 <u> 25mg</u> Start Date & Time Dr. Sign & Bee N9E (Sealmar 29/12/28/10.00 Reg. No:112236 17.00 Stop Date & Time 3/12/23 @9:00 Additional Info: G) Area in-charge Murse Signature:

Clinical Pharmacist - Medway Head Institute

To be filled by Nursing Staff only. Sign and time given Date → REGULAR PRESCRIPTIONS / To be filled in by Doctors only Time ₩ **DRUG NAME** 8,00 TOB. BEPLEX FORTE Dose · Route Frequency 90R PO ltab 100 Start Date & Time 29 12 23 8.00 Dr. Sign Rangen Neyakon ar Reg. No: 112236 Stop Date & Time 31/12/23 @ 10:00 Additional Info: DRUG NAME TOB CLODIDOURFL & ASPIRINI 1/10 4 00 Dose Route Frequency N.66 Clinicalnacist Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR 14.00 0-1-0 Start Date & Time 29/12/23/14.00 Reg. No:112236 Stop Date & Time Additional Info: **DRUG NAME** TAB · AMORVASTATIN Medway Heart Institute Dose Route Frequency 0-0-1 HOMA Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Start Pate & Time 29 12 23 21.00 Reg. No:112236 Stop Date & Time 2 100 21.00 21.00 Additional Info: & wo **DRUG NAME** 8.00 TAB PARACETAMOL Clinical Pharmacist Medway Heart Institute Route Dose Frequency 650 mg 1-1-1 $e_{\mathbf{D}}$ Start Date & Time 29/12/23 20.00 Dr. Sign & KAREEN JEVAR UMAR ... Reg. No:112236 4.00 Stop Date & Time Additional Info: 20,00 DRUG NAME Syp. CREMPERN Dose Route Frequency Clinical Pharmacist Medway Heart Institute 15mL. 0-0-1 Start Date & Time 29 12 23 21.00 Dr. Sign & Reg New JEFAKUMAR Reg. No:112236 Stop Date & Time 21.00 aler O Additional Info: Area In-charge Nurse Signature: 9000

To be filled by Nursing Staff only. Sign and time given Date -> REGULAR PRESCRIPTIONS To be filled in by Doctors only Time **↓ DRUG NAME** 8.00 DILZEM Dose Route Frequency 30mb 1-1-1 Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Start Date & Time 12.00 28/12/23/20.00 Reg. No:112236 Stop Date & Time 20.00 Additional Info: **DRUG NAME** T. METOPROLAL (BETALOL) 10.00 Dose Route² Frequency 12-5 mg Por. 1-0-1 Dr. Sign & Beg. No. / Seal Dr. PRAVEEN JEYAKUMAR Start Date & Time 29/12/23 18.00 22.00 Reg. No:112236 Stop Date & Time Additional Info: HOW 9.10 **DRUG NAME** T. PRECHBALIN . \-9.00 Dose Route Frequency 75mg W Po 1-0-1 Dr. Sign. & Reg. No. / Seal MAR Start Date & Time 29/12/23 9.00 Reg. No:112236 Stop Date & Time Q (+0) 30/11/23 9.00 21.00 Additional Info: × 2 days. **DRUG NAME** 10.00 (BETMa) T. PETO PRO LOL Route Frequency Dose 1-0-1 25mg 10 Start Date & Time Dr. Sign & Reg. No. / Seal 30/12/23 18.00 Stop Date & Time Suzzile OC 99.00 Additional Info: **DRUG NAME** 8-00 T. FRUSEHIDE Dose Route Frequency Long PO 1-0-0 Start Date & Time Dr. Sign & Reg. No. / Seal 31/12/25 12136 Stop Date & Time 211194 80 Additional Info: Area in-charge Nurse Signature:

Clinical Pharmacist

Date -To be filled by Nursing Staff only. Sign and time given REGULAR PRESCRIPTIONS To be filled in by Doctors only 1124 Time 4 DRUG NAME 1000 J. SP, ROND LAKTONE Dose Frequency Route γ Pa 2500 1-0-0 Octinical Pharmarist Morivay Heart In-Start Date & Time Dr. Sign & Reg. No. / Seal 31 11 12 9.00 Stop Date & Time 211124 8:00 Additional Info: **DRUG NAME** 8.00 NEU RO BION FORTE Dose Route Frequency 1 tab Pò 1-0-0 Start Date & Time Dr. Sign & Reg. No. / Seal 21/12/23 9.00 Stop Date & Time فالمحتفظ Additional Info: **DRUG NAME** T. HETIHL COBALAHIN Frequency Dose Route Clinical Pharmacist Medway Heart Institute Suama 0-0-1 P۵ Start Date & Time Dr. Sign & Reg. No. / Seal 21/12/4 21.00 Stop Date & Time 2100 21.00 200 Additional Info: **DRUG NAME** T-ANX IT Dose Route Frequency 0-5mg Dr. Sign & Reg. No. / Seal Start Date & Time 11122 @800 Stop Date & Time (De 112m) D0-00 Additional Info: DRUG NAME T. LASILACTONE Dose Route Frequency 20/50 1/2-0-0 Dr. Sign & Reg. No. / Seal Start Date & Time 2/1/24 8.00 8122 Stop Date & Time Additional Info: Area In-charge Nurse Signature:

Citnical Phe Medway Heart

Clinical Pharmacist
—Medway Heart Institute

Clinical Pharmacist Medway Heart Institute

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To be filled by Nursing Staff only. Sign and time given Date→ **ANTIMICROBIALS** To be filled in by Doctors only DRUG NAME Route Frequency Dose Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: DRUG NAME Frequency Dose Route 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 Dose Frequency Dr. Sign & Reg. No. / Seal Start Date & Time Stop Date & Time Additional info: DRUG NAME Route Dose Frequency Dr. Sign & Reg. No. / Seal Start Date & Time Stop Date & Time Additional Info: Area in-charge **Nurse Signature:**

	ANTIMICRO	BIALS	Date →	To be filled by Nursing Staff only. Sign and time given							
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Dr. Sign & Reg.	No. / Seal	Start Date & Time									
, 		Stop Date & Time	ļ								-
Additional Info:			 	ļ	<u> </u>	<u> </u>	<u> </u>	 	 	ļ	ļ
DRUG NAME				 		- 					
Dose	Route	Frequency									
Dr. Sign & Reg.	No. / Seal	Start Date & Time									
		Stop Date & Time	<u> </u>								-
Additional Info:			 _					,			ļ
DRUG NAME		2 2				ļ			ļ		ļ
Dose	Route	Frequency									
Dr. Sign & Reg.	No. / Seal	Start Date & Time	<u> </u>								
		Stop Date & Time	 		 -	-	-	}	-	_	-
Additional Info:		_ 								 	
Area In-charge Nurse Signatur	·e:										

مرابر بسي

		P	ARENTI	ERAL INFU	JSION P	RESCRIPTION AND ADMI	NISTR	ATION I	RECOF	RD			
Dete	Time	Intravenous	Volume	Rate /		Additive Drug	Do	ctor	Adr	ninistratio	n		
Date	Time	Éluid	volume	Duration	Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign
18 12 23	13.40	KABILYIE	500M	200ml/hr	IV	- '		_	۶	و وحددا	13:40	17.30	avis CON
S 12	1 4.20	KABILVIE	ļ	Some Chr	_\V				8-	112256	17.30	23.300	1007 1007
28/12	21.30	KABILYTE	Soony	100ml/he	ιv		-		۶	112216	22.30	02.30	10 12
29/12	92.30	Kasure	Scorul	100mllu	11/				8 -	112216	02.30	06.30	(8) (18)
29/12	8.30	KABILVIE	Rooul	Moul Br	IV		-	-	8	112236	8.30	11.30	Bus Cotta
29 Jz	11-20	BADILYTE	[Oom]	' ,	- DV				<u> </u>	112236	11.30	30/12/2 4.30	इन्द्र
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		<u>د</u>	ARENTE	ERAL INFL	JSION P	RESCRIPTION AND ADMI	NISTRA	ATION I	RECOI	3D	h	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	-
Date	Time	intravenous	Volume	Rate /		Additive Drug	,		Do	ctor	Administration		
Date	111116	Fluid	volune	Duration	Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.
02 12 0°	14.45	NS 0.9 %.	40al	Aul ha		INY H ACTRAPID	AOTU	470/h	v F	112-236	14.45	01.30	Con S
28/2/23	20.00	Ne 0.9%	20m	smile	14	INI. FENTANLYC	Soonie	4 -	8	طلادا	20.00	05.20	1. rot
29/12/25	08.30	Ne 0.9./.	Sow	25~1/4	1y	INI. DOTASSIUM CHURIDE	20may	-	· <u> </u>	11246,	106.30	OS · 30	C. E.
30 12 23	9.30	NS 0.9%	Soul	Boul By	1/	IN CORDARINE	SONNO		8	11227	9.30	10.30	ais no A
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Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
18/19/2	13-10	NPO	S -	112236	2/1/24	8-0	Normal Dialeticali	189	134559
281223	20.00	Liquip DIET	8	112216					
19/12/2	3 4.00	Léanid diof	8	U2236	<u> </u>			ļ	
30/12/23	£'00	Sout word diet	k.80	134559					٠.
3/12/23	i	Soft solid diel-	W.80	134559					
1/1/24	8:00	soft could diel	11.80	134559			,		

NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
-	Morning			-	1/1/24	Morning	Pavilhea	0072	Park
باداهد	Evening	down FLORANCE'S	0074	Pars	1/1/24	Evening	U. Davila	0(8)	Don
28/12/2	l Nimba	V. Deepalauhmi	. 0101	V. squ	1 1 2	Night	1 Nandfilms	6170	A
29/12/22	Morning	BATA FLORANCES	008A	Saw	2/1/20	Morning	W. Walet	0249	,
2/12/2	Evening	-	mid	naw		Evening			
29/12/2	1 11 - La	SHEEBA D	8270	152%		Night			
30/2/23				phin		Morning		, , , ,	,
30/01-12	l	M Devila	0(2)	165	! 	Evening			t
30/19/2	Night	PIN Bhasa From	J A	9		Night			
sillah	Morning	4. Devila	09	8		Morning			7, -
31/142	Evening	Monisha.	0105	mil		Evening			1
3 / 12/23	Night	RIN Bracette	7227	(Po 4)		Night		,	334



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

Mr.BALASUBRAMANI

62/Malc/MHI202381326 27/12/2023/iPH2023002613

Dr.RAJESH.V





RMEDIATE CARE FLOWCHART

В

UHID NO:

AGE:

SEX:

BLOOD GROUP : $\mathcal{B}^{\dagger V\mathcal{E}}$

HEIGHT: 158CM

WEIGHT: ₹8 kg

B.S.A: 1.86m2

								1			
HAEMODYNAMICS								RESP. PARAMETERS			INVESTIGATIONS /
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA
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	106	ym12	0-01		91	moas	++	ab/vit	BUCL	97%	
	מזו	siny	0-01	60	99	wam	4	20/4	- CL	96%	
197	paj	8 My	0-00	140	79	wan	++	Nolid	CL	96%	
<i></i>	97	siny	0-01	124 70	පිහි	Cuopm	- +}	क्रीय	CL	95%	
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÷ ,	,	Siny	0-00 	121 60	19	wa	+1	22/et	CL	96%	
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										- HOUR	
) DRAINAGE									IOTAL	INTAKE

URINE

TOTAL OUTPUT

BALANCE

OPCABX 3 GRAFIS

LIHA —> LAD

LRA —> D. RCA

The sway to better health (A Unit of United Affiance Healthcare Pvt Ltd)



	Mr.BALASUBRAMANI 62/Male/MHI202381326				M	HI/ICU/2022/076
Name	27/12/2023/IPH2023002613	i				Sheet No.
UHID N	Dr.RAJESH.V		Α	ge -	Sex	,
Blood G	· ~	Height		Weight	BSA	Α
	B POSITIVE	1580m	1	78×91	1.85m2	<u> </u>

SURGICAL PROCEDURE:

DATE OF SURGERY: 28 12 23 POST-OP DAY: DOS

						VENTIL	ATORS P	ARAMET	ERS	•					BLOOD	GAS]
DATE	TIME	MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO₂		рН	PCO ₂	PO ₂	HCO₂	SAT%	BE	
38142	13,35	•		ON	0,	2 M	ASK				buhu			1					
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			-]							 	<u> </u>							유
						<u> </u>					Λ.								CRITICAL CARE FLOWCHART
	13:30		Ckt	No	al (PRONCES					4(jt								L CAF
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	-													_					

PATIENT HAD RELEVED FROM OT:-13.35

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

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	<u>6</u>
	7	8

PUPILS REACTION

CARDIOVASCULAR

D-Dependent

G-Generalised

EDEMA

SI-Sluggish O-Absent
HEART SOUNDS
S1 S2
M-Murmur
Rb-Rub
G-Gallop
SM-Sound muffled

O-Absent 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

NGT POSITION

Air injected

BOWEL SOUNDS

+Present

LIVERSIZE

N-Normal

E-Enlarged

O-Absent	+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

OPLABX 3 GRAFTS
LIHA —7 LAD
LRA —7 D. RCA
SV9 —7 OM

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



Mr.BALASUB 62/Malc/MHI20	RAMANI		M	HI/ICU/2022/076
Name 27/12/2023/IP	H2023002613			Sheet No.
UHID No.	1/81/1841/H 10 H14 814 81	Age	Sex	2
Blood Group	Teigit	Weight	BSA la & Some	A

SLIBGICAL DECCEDLIBE.

DATE OF SUPCEDY: Delialas

Doc POST-OP DAY

SURG	ICAL PR	OCEDU	RE:					DA	re of su	JRGERY	ं यश	12/23		PO	ST-OP D	DAY:	Dos		
			_	,		VENTIL	ATORS P	ARAMET	ERS		•				BLOOD	GAS]
DATE	TIME	MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO ₂		рН	PCO ₂	PO ₂	HCO₂	SAT%	BE	
28/2/22	<u> </u>		0		DASK	٠.	PRON	اسع			<u>slit</u>								
29/12/23									1										_
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]								

NEURO

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

VERBAL

EYES

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 O-Absent

CARDIOVASCULAR

O ,	1000	
HE	ART	SOUNDS
S1	S2	

S1 S2 M-Murmur Rb-Rub G-Gallop 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	SUCTION
Ab-Abdominal TA-Thoraco-abdomial	ET-Endotracheal N-Nasal
L-Laboured	Or-Oral

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

SECRETIONS	CHARACTER
COLOUR	M-Moderate
CL-Clear	Sc-Scanty
Y-Yellow	Th-Thin
W-White	Tk-Thick
Pk-Pink	Cs-Copious
	R-Red

GASTROINTESTINAL

BOWEL SOUNDS	
---------------------	--

+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 OPERS X 3GRAPTS

JUHA - LAD'

JURA - D. RCAP

SV4 - OM

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

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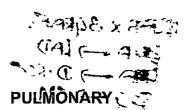


	Mr.BALASUBRAMANI 62/Malc/MHI202381326		_		M	HI/ICU/2022/076
	27/12/2023/IPH2023002613		,	_		Sheet No.
UHID No	Dr.Rajesh.v		A	ge	Sex	3
Blood Gro		TEIGIL	1	Weight Fran	BSA	Α

SURGICAL PROCEDURE:

DATE OF SURGERY: 28/12/23 POST-OP DAY: IDOD

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						VENTIL	ATORS P	ARAMET	ERS		_	_	-		BLOOD	GAS		
DATE	TIME	MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ΙΤV	ETV	FiO₂		ρH	PCO ₂	PO₂	HCO₂	SAT%	BE
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NEURO

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

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

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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

HE	ART SOUNDS
S1	S2
M-N	Iurmur

Rb-Rub G-Gallop SM-Sound muffled

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JVP N-Normal In-Increased

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Valve Replaced / Shunt +Present O-Absent

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SUCTION

ET-Endotracheal N-Nasal Or-Oral

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

CHARACTER
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

62/Male/MHI202381326

		. 92/Matc/MH12023	381326		_			
Sheet No.	Name	27/12/2023/IPH2			_			
1	UHID No.	Dr.RAJESH.V		Ag	ge	Sex		
В	Blood Gro	pup +V	Ξ	Height		Weight	BSA	=m2-





MHI/ICU/2022/076



				вюсн	EMISTRY					VITA	L PARA	METER	S				AC ASSIST	DEVICE	
DATE	TIME	НЬ	Na	к	Ca SUGAR	BLOOD	TIME	ETCO,	BREATH SOUNDS	Sao ₂	RR/MT	N.BP	TEMP°F	Abd ^{om} G.	TIME	IABP	1		R SETTING
		- ""	. 10	 	SUGAR				SOUNDS	0202		1		I		RATIO	DURATION	RATE	MODE
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88/42)			<u> </u>			3.35		<u>L</u>	1000	Mah		100 ·		 	<u> </u>		<u> </u>	
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NEURO	VERBAL			۰ اح	3)	2	
Ä	MOTOR	·		6	6	6	
	ARMS R/L			St	St	2+	
	LEGS R/L			SF	st	21	
PUPILS	R.SIZE/REACTIION			3/13/	जुष्ट	3/37	
F	L.SIZE/REACTION:			3\B7	3/87	න් ලැ	
Ä	HEART SOUNDS			8182	3132	S1 32	
CARDIO-VASCULAR	VALVE CLICK	,		ı	, 1		
-VAS	CAPILLARY REFILL			Br	B.	B	
RDIC	EDEMA			0	0	O	
2	NECK VEINS			N.	7	7	
ARY	WORK OF BREATHING			(JP	JP.	74	
PULMONARY	SUCTION			-	<u></u>	`	
In.	SECREATIONS			-	-		
4	BOWEL SOUNDS			+	+	+	
STIN	ABDOMINAL TONE			S	S	કિ	
NTE	N/G POSITION					-	
GASTRO INTESTINAL	GASTRIC RESIDUAL				_	_	
GA\$	LIVER			N	N	7	

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	DESCRIP.OF URINE			c\	c	प	
G.U.	PD - FUNCTION			-	ì	,	
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	AREA			-	-	_	
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MISCELL	CHEST-PHYSIO	-	•	100 mg		NEB Spino	
MIS	ACTIVITY			p.E	ρÉ	p€	
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	TIME			13,35	16.00	20.00	
	SIGNATURE			Sans	Link	513	_
				V.	O.		

62/Male/MHI202381326

Sheet No.		27/12/2023/IPH20230026 Dr.RAJESH.V	613	1	
2	UHID No.			Age	Sex
В	Blood Grou	B +VE	Height 158m	Weight 구동(속)	1. 85m2





MHI/ICU/2022/076



				BIOCHE	MISTRY					VITA	L PARA	METER:	3			CARDI	CARDIAC ASSIST DEVICE		
DATE	TIME	НЪ	Na	к	Ca SUGAR	BLOOD	TIME	ETCO,	BREATH SOUNDS	Sao,	RR/MT	NRP	TEMP°E	Abd ^{∞™} G	TIME	IABP	,	PACEMAKE	R SETTING
	ļ	115		'`	SUGAR		111111	21002	SOUNDS	0002		14101	1	7.00	11111	RATIO	DURATION	RATE	MODE
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							0130		_4	100%	23 ml								
						_	62.30		el	92%	23 m		92.4	-					
							08.30		4	98.1.	22 mt	ļ							
 	Oq-30				266		04·30		cl	100%	26 mt			,		_			
	100.15	11.7	134	3, 46	1.01		05.30		d	0100.1	25ml					·			
	06.30				227-		06.30		d	96.1.	tolmt		98.3						
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	SHIFT	D	AY	EVE	NING	NIC	ЭНТ	
	TIME					00.00	<u> </u>	
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NEURO	VERBAL					۶	ڲ	
Ä	MOTOR					کم	P	
	ARMS R/L					81-	8	
	LEGS R/L					8+	72	
PUPILS	R.SIZE/REACTIION	1				3 BH	3/81	
PUF	L.SIZE/REACTION					3 81	3/134	
AR.	HEART SOUNDS					2152	<u> </u>	
CARDIO-VASCULAR	VALVE CLICK							
-VAS	CAPILLARY REFILL					134	Bi	
RDIC	EDEMA					O	O	
ර්	NECK VEINS					N	7	
IARY	WORK OF BREATHING					Th	A T	
PULMONARY	SUCTION		_				ł	
PUI	SECREATIONS					-	—	
٦-	BOWEL SOUNDS					+	4	
STIN	ABDOMINAL TONE					\$0	ठ०	
NTE	N/G POSITION					-		
GASTRO INTESTINAL	GASTRIC RESIDUAL					-	•	
GA	LIVER					N	N	

3	NIC	SHT		SHIFT	D/	ΑΥ	EVE	NING	NIC	SHT
	00.00	<u>04.00</u>		DESCRIP.OF URINE					리	વ
	4	4	G.U.	PD - FUNCTION					-	,
	5	5		DRAINAGE						-
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	8+	-12.		COLOUR					-	-
	_	3 8		Sx WOUND-CHEST						0
	<u> 3</u> 81	2/31		LEG					C.)	d
	2152	2212	SKN	DRESSING					07	04
				PRESSURE SORE-SITE					ΛUL	Nu
	<i>О</i> 134	<u>Br</u>		AREA					_	
	N	N		DRESSING CONDITION					-	}
	7'p	44		POSITION CHANGE					વિત્રમ	Q24+
	-		MISCELL	CHEST-PHYSIO					NEB	NER. Spine
	-	<u>-</u>	MIS	ACTIVITY					ρ∈	p∈
	8-1	40							ABP Wp	ABP CUP
•	3			S/N NAME					Deepe	Deep
	ţ	-		TIME					00.00	0५.०
	2	7		SIGNATURE					0.785	KOY

62/Malc/MHI202381326

Dhard Na		27/12/2023/IPH2023002613	•		<u>-</u>	
Sheet No.		Dr.RAJESH.V				
_3	UHID No.	<u> </u>	<u></u>	Age	Sex	
В	Blood Grou	up +VE	Height	Weight	BSA	
_		B +v∈	158m	Fores	1.850	





MHI/ICU/2022/076



				BIOCH	EMISTRY		_			VITA	L PARA	METER:	<u> </u>			CARDIA	AC ASSIST	T DEVICE	
DATE	TIME	Hb	Na	К	Ca	BLOOD	TIME	ETCO,	BREATH SOUNDS	Sao,	RR/MT	N BB	TEMD°E	Abd ^{cm} G	TIME	IABP	r		R SETTING
		טרו	IVa	<u> </u>	SUGAR	BLOOD	1 11415	E1CO2	SOUNDS	Sau	KROWII	IN ₁ DF	I EIVIF F	Abu G	IIIVIE	RATIO	DURATION	RATE	MODE
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岁	моток	6	6		
	ARMS R/L	\$	JE		
	LEGS R/L	SE	St		
PUPILS	R.SIZE/REACTIION	2\B1	3/05		
PUF	L.SIZE/REACTION	3/137	3/87		
꿁	HEART SOUNDS	5152	5182		
CUL	VALVE CLICK	-	-		
CARDIO-VASCULAR	CAPILLARY REFILL	Br	BY		
RDIC	EDEMA	0_	D		
ეგ	NECK VEINS	И	N		
IARY	WORK OF BREATHING	SP	J.P.		ļ
PULMONARY	SUCTION	1			
154	SECREATIONS	-	_		
 -	BOWEL SOUNDS	+	+		
STIN	ABDOMINAL TONE	Ş	8		
INTE	N/G POSITION	_	_	·	
GASTRO INTESTINAL	GASTRIC RESIDUAL		_		
GAS	LIVER	N	N		

	SHIFT	С	PAY	EVE	NING	NIC	SHT
	DESCRIP.OF URINE	وا	c				
G.U.	PD - FUNCTION						
J	DRAINAGE	_					
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	COLOUR	_	_				
	Sx WOUND-CHEST	cl	c\				
	LEG	cl	cl				
SKN	DRESSING	ર્જા	61				
	PRESSURE SORE-SITE	Nil	121				
	AREA	ı					
	DRESSING CONDITION	-	-	-			
	POSITION CHANGE	QaH	MA				_
MISCELL	CHEST-PHYSIO	200.00	3000				
MIS	ACTIVITY	6,5	9.6				
		1990 E	NOS			<u> </u>	
	S/N NAME	Olding.	SW				
	TIME	3.00	12.00				
	SIGNATURE	(Paris)	Surge				

Medway Hospitals
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	Mr.BALASUBRAMANI 62/Malc/MHI202381326		М	HI/ICU/2022/076
Name	27/12/2023/IPH2023002613			Sheet No.
	Dr.RAJESH.V	1		·
UHID No.		Age	Sex	` `

Weight

BSA

1.8m2

C

Height

158m

		UR	INE		CHEST DRAINAGE				GAS	TRIC	LAB S	AMPLE		You	ME	INF	USIONS			
DATE	TIME	AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT						
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Blood Group

B

POSITIVE

SPECIFIC OBSERVATIONS/PROBLEMS

DATE TIME

Act: 101 Ofce at 14.35

CRITICAL CARE FLOWCHART

GENITOLIRINARY (GU)

	GENITOURINA	RY (GU)			SKIN	
	PD			COLOUR	SURGICAL (SX) WOUND	
URINE	FUNCTIO	N	DRAINAGE	Pk-Pink F-Flushed P-Pale	C-Clean Oz-Oozing G-Gaping	B-Betadine Al-Antibiotic Irrigation
CL-Clear T-Turbid	Dr-Drainir B-Blocked		CL-Clear BS-Blood	Cy-Cyanotic M-Mottled	Op-Open I-Infected	migation
Stained HC-High Coloured	SITE			D-Dusky J-Jaundice	`	,
BS-Blood Stained HA-Haematuria	C-Clean R-Rednes	ss discoloration			PRESSURE SORE	
	MISCELLAN			SITE S-Sacrum Sc-Scapular	AREA R-Redness BD-Black discoloration	DRESSING / Rx IR-Infra Red DU-Dueodem
OISITION CHANGE Su-Supine RL-Right lateral LL-Left Lateral ACTIVITY PE-Passive exercise Am-Ambulated	MIOCELAN	V-Vibrator CP-Chest per DC-Deep bre N-Nebulizer TRANSDUCI PARAMETER ABP-Arterial RAP-Right A	rcussion eath & cough ER ZERO R BP rterial Pressure ary Arterial Pressure	CONDITION H-Healing SCo-Status quo S-Sloughing LINES / TUBES	BL-Blister SP-Skin Peeling D-Deep CONDITION welling, no leak, no air e ite	E-Eptoin dressing B-Betadine dressing EU-Eusol sitz bath ST-Sofra Tulle

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62/Male/MHI202381326			M	HI/ICU/2022/076
Name 27/12/2023/IPH202300261 Dr.RAJESH.V	3			Sheet No.
UHID No.		Age	Sex	2_
Blood Group	Height	Weight 1 31∠93	BSA lifsm'	С

		UR	INE	_	CH	IEST DI	RAINAC	E		GAS	TRIC	LAB S	AMPLE		Voi	UME		USIONS]
DATE	TIME	AMT	TOTAL	RT.PL.	LT.PL.	MED &	PERIC	HR.T	G.T.	AMT.	TOTAL	АМТ.	TOTAL	TOTAL OUTPUT	Ami	torne	Acter 40 lyc	F 119 500 20	•]
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)1. <i>30</i>	100	235			30		30	380		e		8.0	1623	100	1400	2.0	1.0			
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SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

GENITOURINARY (GU)

GE	MITOURINAR	Y (GU)			OKIII					
	PD			COLOUR Pk-Pink	SURGICAL (SX) WOUND C-Clean	DRESSING B-Betadine				
URINE	FUNCTION	TION 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	migaton				
Stained HC-High Coloured	SITE			D-Dusky J-Jaundice						
BS-Blood Stained HA-Haematuria	C-Clean R-Redness				PRESSURE SORE					
пА-паетаluna	BD-Block di	scoloration		SITE	AREA	DRESSING / Rx				
ı	MISCELLANE	ous		S-Sacrum Sc-Scapular Oc-Occiput	R-Redness BD-Black discoloration BL-Blister	IR-Infra Red DU-Dueodem E-Eptoin dressing				
OISITION CHANGE	C	HEST PHYS	10	Oc-Occiput	SP-Skin Peeling	B-Betadine dressing				
Su-Supine RL-Right lateral LL-Left Lateral	0	/-Vibrator CP-Chest perc CC-Deep brea			D-Deep	EU-Eusol sitz bath ST-Sofra Tulle				
ACTIVITY		l-Nebulizer		CONDITION						
PE-Passive exercise Am-Ambulated	P	RANSDUCE PARAMETER ABP-Arterial B		H-Healing SCo-Status quo S-Sloughing						
			erial Pressure ry Arterial Pressure	LINES / TUBES CONDITION						
		AP-Left Arteri		O-No redness, sw R-Redness at site Sw-Swelling at sit Dr-Draining D/c-Discontinued P-Positional HL-Heparin Lock B-Blocked	te					

SKIN

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		ASUBRAMANI /MHI202381326				N	IHI/ICU/2022/076
		2023/1PH20230026					Sheet No.
UHID No	Dr.RAJE	sh.v Maria	W 1114 114	A	ge	Sex	_3
Blood Gro	oup	B TVE	Height	1	Weight	BSA 1,85m²	С

		UR	INE		Cŀ	EST D	RAINAG	E		GAS	TRIC	LAB S	AMPLE	TOTAL	(C	ww		JSIONS	
DATE	TIME	AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT	Апп	Corne	Ku 20 50		
29/12/23	DA. 24	60	(bas			lo		10	10				_	<u>쿠0</u>			QS.0		
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	No. 35	150	1535						0,00					1655		600			

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME	9.30 HE	JANITEAIA	and reti	PLEURAL	DRAIN REHOVED	LAR ANBARASU
		10.00 RI	WHI RADIA	al drieria	L RINE	REMOVED [DR. 1	PRAVISEN]

GENITOURINARY (GU)

GE	NITOURINARY (GL	וי		Oran				
	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 Stained	Dr-Draining B-Blocked	CL-Clear BS-Blood	Cy-Cyanotic M-Mottled D-Dusky	Op-Open I-Infected	migation			
HC-High Coloured	SITE		J-Jaundice					
BS-Blood Stained HA-Haematuria	C-Clean R-Redness			PRESSURE SORE				
	BD-Block discolo	ration	SITE	AREA	DRESSING / Rx			
ī	MISCELLANEOUS		S-Sacrum Sc-Scapular Oc-Occiput	R-Redness BD-Black discoloration BL-Blister	IR-Infra Red DU-Dueodem E-Eptoin dressing			
OISITION CHANGE	CHES	T PHYSIO	Oc-Occiput	SP-Skin Peeling	B-Betadine dressing			
Su-Supine RL-Right lateral LL-Left Lateral ACTIVITY		est percussion ep breath & cough	CONDITION	D-Deep	EU-Eusol sitz bath ST-Sofra Tulle			
PE-Passive exercise Am-Ambulated	PARAI	SDUCER ZERO METER Arterial BP	H-Healing SCo-Status quo S-Sloughing					
		Right Arterial Pressure ulmonary Arterial Pressure	LINES / TUBES CONDITION					
	LAP-L	eft Arterial Pressure	O-No redness, swelling, no leak, no air R-Redness at site Sw-Swelling at site Dr-Draining D/c-Discontinued P-Positional HL-Heparin Lock B-Blocked					

SKIN

62/Male/MHI202381326

27/12/2023/IPH2023002613 Name

Dr.RAJESH.V

Blood Group

UHID No.

+VE 158vm

Flokes

Sheet No. Age Sex Weight BSA D

1,2500





MHI/ICU/2022/076



Every heart beat counts

FLUI	D ASSESSMENT (contd.)
i	

HAEMODYNAMICS

Blood Group:

B+VE

		INFUSIONS (contd	.)		N/G/	ORAL	TOTAL	TOTAL	un.	D)CTINGA					LAP/		PP				
DATE	TIME		MIX	TOTAL	AMT.	TOTAL	INTAKE	BALANCE	HR/mt	RYTHYM	ST	ABP	MAP	RAP	RAP	PERI	R/L	CO	CI	SVR	
নিধা য়	13,35		 						70	SIZW	Oioi	15/43	ક્રમ	ঝ		cod	FIF				
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	16.30		2.0	6.0			A10	220	_	SINDS		122	18	T A		(DOYL	FF	!			
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	2-30		2.0	6.0	20	200	1336	+ a	l De	Elmn	о ьч	143 - 20		B		WARm	+ +				

STAT DRUGS TIME

@ 20,00 T. ELOSPRIN ASMU Plo STATICULEN PREVIOUS DAY HRS

DRAINAGE:

TOTAL INTAKE:

URINE:

TOTAL OUTPUT:

TOTAL BALANCE:

	DAY	EVENING	NIGHT
PATIENT CARE			
BATH			
ORAL CARE			
EYE CARE			
BACK CARE		V	
DRESSING/EQUIPMENT			
CHANGED			
WOUND			
CEN.LINE			
I.V.SET			
TUBINGS			
HUMIDIFIER H2O			
ELECTRODES			
ALARMS VERIFIED			
VENT - HUMIDIFIER			
-SETTINGS			
HRT.RATE		Folmt	
B.P.		15117218U	

DATE	TIME	REMARKS / PLAN

INFUSION PU		INSERTION	1	INFUSION/	1	 	Т
LINES/TUBES	SITE	DATE	DAYS	DRAINAGE	DAY	EVE	NI
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62/Malc/MH1202381326

27/12/2023/IPH2023002613 Name

Blood Group

Dr.RAJESH.V

UHID No.

Sheet No. Sex Age 2_ Weight BSA D

1.85m2





MHI/ICU/2022/076



Every heart beat counts

FLUID ASSESSMENT (contd.)

BTVE

Height

158cm

HAEMODYNAMICS

Blood Group:

BtvE

			INFU	SIONS	(contd.)			N/G	ORAL	TOTAL	TOTAL	UD/ 1	D) CT I D (I					LAP/		PP			0.75
DATE	TIME					Muc	TOTAL .	AMT.	TOTAL	INTAKE	TOTAL BALANCE	HR/mt	RYIHYM	ST	ABP	MAP	RAP	LAP/ RAP	PERI	R/L	CO	CI	SVR
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	03.30					2.0	3.0		200	1852	39	606	SINU	10.03		ૠ	5		WAKIN	1+	i		
	04.30					2.0	3_0		200	1954	+ 56	108	Sinu	Go Ø		86	6		LIARUM	++			
	05°30					2.0	<i>3</i> .0	100	300	2) 54	179	106	enuu	0 03 — .		ક્ય	4	_	WARN	44	L		
	06.30					2.0	2.0		300	2359	3w	118	S (ML	0.06	<u> 148</u> 54	६ ३	7		LUARA	1 ተ ታ			
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URINE:

TOTAL OUTPUT:

TOTAL BALANCE:

	DAY	EVENING	NIGHT
PATIENT CARE		1	
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			
B.P.			

DATE	TIME	REMARKS / PLAN
		<i>.</i>
		```

INFUSION PU	IMPS	,					
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
TIL	TIL	28/12/23	1				,P
ART LINE	RIT	8भागित्र	1				P
PERILINE	mΒ \$1	28/12/2-3	1				P
IN EXTN		वेक्षाय्य	1				Ρ
MEDIA		24/12/23	1				P
PIEURAL	LT_	28/12/23					P
TR-DOINE		20/12/23	1		-	<u> </u>	P
U-CATH		28/14/23	1		ļ		P
2-TUBING		28/12/23			<u> </u>	<u> </u>	P
O_TUBING		28/11/23	1			ļ	P
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62/Male/MHI202381326

	02/Maic/	MILLITOTOGICE						
Name		023/12H2023002613	3			SI	heet No.	
UHID No.	Dr.RAJES	эн.v Ш <u>Ш</u> МППНШМ		\ge	Sex		3	_
Blood Grou	db	R+VE	Height	Weight	BSA		D	





MHI/ICU/2022/076



Every heart beat counts

		FLUID	ASSESSME	ENT (con	td.)	2.24	£ 1 de	<b>1</b> 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	HAEN	IODYNA	MICS						Blo	od Gre	oup:	BT	VG	
DATE	TIN 45		INFUSION	IS (contd.)	)		N/G/	ORAL	TOTAL	TOTAL	UD/mt	RYTHYM	07	ADD	1460	D 4 D	LAP/	PERI	PP	00	CI	SVR
DATE	TIME				nusc	TOTAL	AMT.	TOTAL	INTAKE	BALANCE		Kiluliá	ō	ABP	MAP	RAP	RAP	PERI	R/L	-00	G.	SVK
9/2/2	ወ4-34	_			2.0	<del>21</del> -0	50	50	77.0	4.0	114	SINUL TAGI	0.0	114	<del>१</del> 2	_5		Warm	44			
	8.30	<u> </u>			200	27.0	_	50	ro A	726	111	SINES	००म	126	76	ゟ		(DOYN	ተታ			
	9·3a				ನಿ.ರ	2.0	too	150	306	101	110	રિક્લપડ	.6.04	159	95	8.		BAFIT	4-1-			
	10.30	)					150	200	506	451	88	BINLUS	DOA		_			Darm	4.4			
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	13.30							350	8F/b	299	102	SIMUS	0.06					MIRE	नन			
	1A:30	<u> </u>					150	500	956	299	10F	SMOS	0.00	-	_			COON	4.4			
_	分30							500	956	TAG	100	>mos	D-0p				(	COOT P	44			
	16.31							F00	956	599	1	SINUS	l					lann	4			

STAT DRUGS TIME PREVIOUS DAY ...... HRS 55 minls

DRAINAGE: 400m TOTAL INTAKE: 2359 mL

URINE: 1635 ML TOTAL OUTPUT: 2049 ML

TOTAL BALANCE: +310me.

	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	1,1		
HRT.RATE	845/	60	
B.P.	1 109	Ψογ	
	100 1001	utt)	

DATE	TIME	REMARKS / PLAN	
	i.		

INFUSION PU	MPS						
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
JIL	媊	28/12/22	2		P	P	
ARTUNE	缸口	22/12/22	2		P/#	R	
PER UNE	田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田	28/12/23	2		P	P	
The EXTH		<u> </u>	2		P	12	
MEDIA		28/12/23	2		P/F	R	
PLEURAL	T	dd12123	2		PR	R	
TR-DOME		28/12/23	2	<u> </u>	1/1/6	R	
V-VATH		23/12/23	2		P	?	
S-TVBIHU		23/12/23	2		PR	R	-
OL-TUBIHI		22/12/21	2		P/R	R	
N. PROMYS		28/12/23	2		PR	R	
,			<u> </u>	<del>-</del>	<u> </u>	<u> </u>	
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62/Male/MHI202381326 27/12/2023/IPH2023002613

Dr.RAJESH.V

NAME:

# *IMEDIATE CARE FLOWCHART*

**UHID NO:** 

AGE:

SEX:

SURGICAL PROCEDURE: OPCABX 3GRAFF9

POSTOP DAY: I POD

FLUID REQUIREMENT: 2.2 (at ) lag.

DATE &	URI	INE	CHEST DRAINAGE				TOTAL	I.V. FLUIDS				ORAL	_/ R.T.	TOTAL	TOTAL
TIME	H.T.	G.T.		AIR LEAK	Н.Т.	G.T.	OUTPUT				H.T.	н.т.	G.T.	INTEKE	BALANC
30]3b H-30											_	150	150	50	+ 50
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11.30		6FG	)				550	_		_		150	350	A 50	100
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_		SSERVA								/ DRUG					

MHI/ICU/2022/064



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

Mr.BALASUBRAMANI

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

Dr.RAJESH.V

NAME: IRMINIMUM MINIMUM MIN

RMEDIATE CARE FLOWCHART

**BLOOD GROUP:** 

**UHID NO:** 

AGE:

SEX:

158 cm **HEIGHT:** 

WEIGHT: 78 Kg

B.S.A: ('86m²

		HA	EMOD	YNAN	iics	•	-	RESE	P. PARAMET	ERS	INVESTIGATIONS /			
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	INVESTIGATIONS / OTHER DATA			
1026	130	SINUS (PICH)	0.01	138	98	Corru	44	33 H	BL(Cl	90%	DN room rux.			
	<i>[30</i>	Jeeh7 Siyaz	0.00	1.6k	103	LOOTIN	44	3A W	cl	90%				
	126	SIMUS JAYM	000	127	89	10arin	44	BERNA	- cl	907.				
	100	SIMOS	0.01	160		LOATIN		16/4	t cl	90%				
	90	Shows	orol	114	おと	(Davh	<del>t</del> t	24 rut	c	90 Y				
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PREVIOUS DAY - HOURS 2HHRS.

DRAINAGE

dome

TOTAL INTAKE 2606 ml

URINE 2620 MU

2640 m TOTAL OUTPUT

BALANCE -34 ml.







onit of Orited Amarice Realistate PVI Ltd.

Mr.BALASUBRAMANI 62/Male/MHI202381326

27/12/2023/IPH2023002613

Dr.RAJESH.V

NAME:

# RMEDIATE CARE FLOWCHART

A

**UHID NO:** 

AGE:

SEX:

SURGICAL PROCEDURE:

POSTOP DAY: POD

OPCABX 3 GRAFTS

FLUID REQUIREMENT: 2 2 1 Lay.

X 12 03

DATE	URINE CHEST DRAINAGE						I.V. F	LUIDS		ORAL/ R.T. TOTAL					
& TIME	H.T.	G.T.	01	AIR LEAK	H.T.	G.T.	TOTAL OUTPUT				н.т.	H.T.	G.T.	TOTAL INTEKE	TOTAL BALANC
12.3D	100	1635			-	20	1655				600	100	600	1056	699
اہ. `ا		12/10				90	1730				600	150	650	1106	6NA
19.30		0181				<u> </u>	1830				600		850	1106	724
20-30	IDD	191a				2p	1930				600	100	750	1206	804
J1-30	80	<u> १९९०</u>				20	2010				600	150	900	1356	654
J2-30	ነታሪ	2) <del> </del>  D				20	2160	FBB)	HI	-	600	100	1000	1456	ने०4
)3-30	扔	2215	-			90	2235	100		तवा	700	100	1100	1656	<u> जिल</u>
00-30 30(12),	80	2295	-			20	2315	100	(	200	800		1100	1756	559
80(12g) 81-30	75	2370				Nο	2390	too		300	900	-	1100	1856	534
ల్ఫి.30	<del>1</del> 5	24 <i>4</i> 5				90	2465	lop		400	loco	lbo	1200	2016	409
93 <b>.</b> 30	001	<u> 2545</u>	-	ı		એ <b>ઇ</b>	2565	100		500	lloo		1200	2156	409
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05.3p		262b				20	26 4p.				1100	150	1450	2406	284
<i>06-</i> 30		2620				20	2640				1100	એ ૦૦	1650	2806	34
_															

SPECIFIC OBSERVATIONS/REMARKS

@4.30. Folloy's Removed.

cotheter

MEDICATION / DRUGS