

MRD CHECKLIST

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





P; Mr.SOMASUNDARAM M N: 47/Male/MHI202379692 U; 05/11/2023/IPH202302190





Every heart beat counts

Medway Hospitals The way to better health

(A Unit of United Alliance H	ealthcare Pvt Ltd)	ADMISS	ION SLIP	
Admitting Doctor: $\mathcal{D}_{\mathcal{Y}}$	RAJESH. V		Speciality: (Coud Po	thoracic Surgery
Advised Date & Time:	05/11/83@	10'.20'		
Provisional Diagnosis:	•			
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9	N. G.		-	malox OM
	Border	ine LAC	nt costfeal	J-
Reason for Admission:	Medical Manage	ment 🔽	Surgical Management	
	Others (please sp	pecify details) _	CABGI	
Admission Type:	Day Care	ER V	Ward	
	☐ ICU	(Sp	ecify details)	
Surgery / Procedure Nam	e (if planned):			
g, , ,				
	CABOT_			
Blood Product Requireme	ent: No Yes	Kindly specify deta	ils of components required i	n space below)
			<u> </u>	
Expected Duration of Stay	1: 1-7 day	18.		
Expected Cost of Treatme	nt (as per Financial Col	-	and the second of the second o	
Payer: Self Insuran	ce Others:	Esi 📑		
Instructions to Nurse (if ar	ny):			
	consent			•
	consent			
Any other instructions (if				
Any other Instructions (if a	-			
Dr. V. R A M.S. M.Ch				
Senior Co	nsulturit			
V Wyll	resultationer			
Doctor's Signature	Name	Re	g. No.	Date Time
for \$15032	DR . RAJE	SH	62794	05/11/23 11/2

Room Category: General Ward Single Room Twin Sharing Deluxe Room Suite Room Others Admission Intimation Receipt Details Date Time Date Time Date Time Doste Doste Time Doste	or admission desk	staff only:		
Twin Sharing Deluxe Room Suite Room Others Admission intimation Receipt Details Date Time Date Time Date Time 05-1) - 2023 Source: OPD ER Direct To be filled only if Blood requirement specified by the Doctor: Is Blood Reservation and Blood Bank clearance completed as advised: Is Blood Reservation and Blood Bank clearance completed as advised: Imp. No. Date Time	Room Category:	General Ward		
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Admission intimation Receipt Details Date Time Date Date Time Date Time Date Date Time		Deluxe Room		
Admission intimation Receipt Details Date Time		Suite Room		
Date Time Date Time Date Time Date Time Date Time Date Time Date Time Date Time Date Time		Others	· -	 .
Source: OPD BR Direct To be filled only if Blood requirement specified by the Doctor: Is Blood Reservation and Blood Bank clearance completed as advised: Yes No ont office Staff Signature Name Emp. No. Date Time	Admission intir	nation Receipt Details	Admission Ti	me in HIS
Source: OPD ER Direct To be filled only if Blood requirement specified by the Doctor: Is Blood Reservation and Blood Bank clearance completed as advised: Yes No ont office Staff Signature Name Emp. No. Date Time	Date	Time	Date	Time
☐ ER ☐ Direct To be filled only if Blood requirement specified by the Doctor: Is Blood Reservation and Blood Bank clearance completed as advised: ☐ Yes ☐ No ont office Staff Signature Name	15-11 - 2023		05+11-2023	
nt office Staff Signature Name Emp. No. Date Time				
		Direct Blood requirement specified by	·	□ No.
RESHUP BANU. MAI 0264 103-11-203 10:00	Is Blood Reservation	Direct Blood requirement specified by on and Blood Bank clearance of	completed as advised: Yes	
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(A Unit of United Alliance Healthcare Pvt Ltd)



Mr.SOMASUNDARAM M Patient Deta 47/Mulc/MHI202379692 05/11/2023/IPH202302/90 UHID: DOB:

Dr.RAJESH.V



Consultant:

DOA:

ADMISSION FORM

Marital Status	s Full Add	Iress		0	ENT O-DATE D	Telephone Number
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Referred from	 n	Date of Tin	ne of Admission	Date & Time of Disc	charge Total	No. of Days
	طهمت	ŀ			_	5 days
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(ondi		MLC	☐ Yes	□ No If Ye	es AR No. :	
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DATE			OPERATION /	PROCEDURES		ICPM Code
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DATE				NESTHESIA		
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			DISC	HARGE STATUS		
Cured			scharge at Req		□ Ex	pired < 48 hours
☐ Improved	Dr. V. R	Ag AJESHAb Bh(CT√S)	ainst Medical A	Advice	□ Ex	pired > 48 hours
☐ Unchang	M.S, M.C jed Senior Co diothorpole and	h(CTVS) ⊃nsul ⊡₁Tra LVasc⊢lar c	nsconaea Insferred to		🗀 Po	st-Operative Death
√ Signature	Reg No.	Kil My	urg		S. Aleun Signature of Medic	eal Records Officer

AUTHORISATION FOR TREATMENT I PAYMENT

AUTHOR	NISATION FOR TH	EATMENTTPAYMENT
administer such drugs as may be ned	cessary and to perform suc e in the diagnosis and treat	Paramedical, Staf f of the Hospital Investigate treat and h operation under anaesthesia or other wise as may be ment of my illness / patientSOMASUNDARAM
I hereby under take to settle all the bi basis. In any case, I shall pay all the o	,	es related to me/the patient named overleaf on a periodic ged from the hospital.
•	•	agreed above, I hereby authorise the hospital to transferent as deemed fit and proper by the hospital authorities.
-	nt or theis attendants have	nd Regulations of the Hospital and that all cash, jewellery been removed to a place of safety / handed over to the egard to any loss.
I have read out and explained the cor		•
சிகீச்சை, பணம் செலுத்துதல் முதலியடை	வ சையய அத்காரம் வழங்குத்	,50
		வ ஊழியர்கள் எனக்கு / நோயாளி
	றுவை சிகீச்சை செய்யவும் அ	ட சோதனைகளை செய்து மருந்துகளை கொடுக்கவும். மயக்க தீகாரம் வழங்குகிறேன். நான் / இதீல் குறித்துள்ள நோயாளின் றேன்.
		லவுகளை கட்டத் தவறினால் என்னை நோயாளியை வேடுறாரு ஒப்புதலை எனது உறவினர்கள் மூலமாக பெற நான் அதிகாரம்
மருத்துவமனையின் பொது சட்ட திட்டங்க	எள் பற்றி தெரிவிக்கிப்பட்டிருக்	93 றன்.
•	•	்கள் யாஷம் பாதுகாப்பான <i>இடத்தி</i> ற்கு மாறுபட்டுவிட்டன / அல்லு சு எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை
மேற்குறிப்பிட்ட அனைத்தும் எனக்கு வி	வரிக்கப்பட்ட பிறகுதான் கைவெ	பாப்பலிட்டேன்.
Roffer		
^\° ் செவிலி யர் கையொ்பம்	தேதீ	எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of Admitting Nurse

Date **20**5-11-2013

Signature of the Patient / Relative / Gurdian

180m

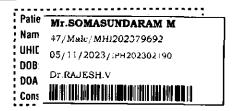
உறவுமுறை

Nature of Relationship



promise to abide by them.

texts accompanying them do not reveal my identity.





GENERAL CONSENT FOR ADMISSION

Ι, _	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.
•	I also consent to be administered necessary drugs, medications, intravenous fluids, as advised 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 as a patient as outlined in the patient handbook.
•	I have been made aware of the rules and regulations of the hospital including those related to security and I

I also consent and agree to the use and/or publication of my treatment details / medical record for medical, scientific or educational purposes (Teaching, research and academics) provided the pictures or the descriptive

- 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 also consent to receive communication on treatment related information via text messages and e-mail as per the details provided at the time of registration.
- 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	M. Ednbdajaja	Roma Sundaramin	05-11-2023	10:28 F
Surrogate/Guardian (if applicable #)	600 m	MEEWA (Write name and relationship with patient)	05-11- 2023	10:28 B
Reason for surrogate consent	Patient is unable to give consent	because:		
Witness	- Real-	JR ESHIMA BANU.	05-11-2023	101,28
Interpreter (if applicable)	0 0-2			

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



Mr.SOMASUNDARAM M

47/Male/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V





ADMISSION CRITERIA FOR INTENSIVE CARE UNIT

S. No.	PARAMETERS	MARK APPROI	
	Homodynamia instability defined as		111,7,7,1
	Hemodynamic instability defined as Pulse less than 40 or more than 150 beats/minute		
	Systolic arterial pressure less than 80 mm Hg or 20 mm Hg below the patient's usual pressure		<u> </u>
1	Mean arterial pressure less than 60 mm Hg		
	Diastolic arterial pressure more than 120 mm Hg		 -
	Respiratory rate more than 35 breaths/minute		<u> </u>
	nespiratory rate more than 35 breaths/minute		
	Cardio-vascular System		i
	Acute myocardial infarction		
	Cardiogenic shock		
	Complex arrhythmias requiring close monitoring and intervention		Ì
	Acute congestive heart failure with respiratory failure and / or requiring hemodynamic support		
2	Hypertensive emergencies		
	Unstable angina, particularly with dysrhythmias, hemodynamic instability, or persistent chest pain		
	Post cardiac arrest		
	Cardiac tamponade or constriction with hemodynamic instability		
	Dissecting aortic aneurysms		
	Complete heart block		
	Miscellaneous Conditions		
_	Septic shock with hemodynamic instability		1
3	Hemodynamic monitoring		
	Clinical conditions requiring ICU level nursing care		
	Post procedure elective admission		
4	Post Coronary Angioplasty		
į	Post Cardio-vascular Surgery		
	Following angiographic procedure		
	Complication resulting from the angiographic procedure including any significant change in pulse in the		ĺ
	affected extremity, neurologic changes, persistent bleeding, or persistent nausea and vomiting post-		
5	procedure		
	Significant findings on diagnostic angiography warranting further therapy that would necessitate inpatient		
	admission is also a reasonable indication for admission		
	Admission at the time of the study is encouraged if problems are suspected or arise		<u></u>
	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 deterioration		
	Need for nursing / respiratory care not available in such intermediate care units	<u> </u>	
	Massive hemoptysis		ļ
	Respiratory failure needing imminent intubation		
	Renal failure		1
-	Oliguria or anuria for more than 12 hours		
7	Metabolic acidosis (pH < 7.1)		
	Patients requiring hemodialysis can be performed in ICU when the blood pressure is borderline		1

		PARAMETERS					RK √ AS IOPRIATI
	Endocr Diabetic insuffici	atory					
	Thyroid						
- 1			or hemodynamic instability or Sei		ore than 800 mg/di		
			adrenal crises with hemodynamic Calcium more than 15 mg/dl) v		antal status roqu	iring	
		namic monitoring	Jaiolam More than 15 mg/dij v	WILL ALLOIDE H	rentai status, requ	"""9	
	-		dium less than 110 mEq/L or more	than 155 mEq	/L) with seizures, alt	ered	
	mentals		emodynamic compromise or dysrh	wthmine			
j			assium less than 2.0 mEq/L or mor		ı/L) with dvsrhvthmi	as or	
	muscul	ar weakness	·				
	Hypoph	osphatemia with muscular	weakness				
		Signature	Name		Reg. No.	Date	Time
Do	ctor				<u> </u>	 	
		Y	Dr. pravosu for	w Knows	112236	6/1/22	14.0
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1 2 3 4 5 6 7	Stable in Stable in Minima Intraver Cardiac Present No sign	nemodynamic parameters espiratory status (Pt. extub l oxygen requirement (not mous / Inotropic / Vasopress dysrhythmias are controlled ce of distal pulses is of bleeding and hematom	PARAMETERS ated with stable arterial blood gase nore than 3 L by nasal prongs) for support and vasodilators are no	es) & airway pa	tent	MA	





D.O.A

D.O.D

Room No. : GN

(A Unit of United Alliance Healthcare Pvt Ltd)

: 05/11/2023

: 10/11/2023



DISCHARGE SUMMARY

IP No.

: IPH202302190

: MHI202379692

UHID Name

: Mr. SOMASUNDARAM.M

Age / Gender : 47Years / MALE

Consultant

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

Senior Consultant Cardiothoracic and Vascular Surgery

D.O.S: 06.11.2023

DIAGNOSIS:

DOUBLE VESSEL CORONARY ARTERY DISEASE

ACUTE CORONARY SYNDROME - NON ST ELEVATION MYOCARDIAL INFARCTION -SEPTEMBER 2023

NORMAL LEFT VENTRICULAR SYSTOLIC FUNCTION - EF: 60%

TYPE 2 DIABETES MELLITUS

SYSTEMIC HYPERTENSION

SURGERY:

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 2 GRAFTS: LIMA TO LAD, LEFT RADIAL ARTERY TO MAJOR OM DONE ON 06.11.2023

BRIEF HISTORY:

Mr. Somasundaram.M,47 years old male, a known case of Type II diabetes mellitus, Systemic hypertension, Acute coronary syndrome - Non ST elevation myocardial infarction, CAD - double vessel disease, Normal LV systolic function, has come for CABG. Patient was apparently normal till 2 months when he developed chest pain - retrosternal, radiating to right shoulder, jaws and back. Initially, he went to ESI hospital and was diagnosed as ACS - NSTEMI. He was managed conservatively and advised Coronary angiogram. He was referred from ESI to Medway Heart Institute on 25.09.2023 and underwent Coronary angiogram which showed Double vessel disease. He was advised for CABG.

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

@MedwayHospitals

Kodambakkam

@medwayhospitals

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Medway Group of Hospitals

Medway Centre of Excellence (Chennai)





(A Unit of United Alliance Healthcare Pvt Ltd)

UHID: MHI202379692 IPNO: IPH202302190

Patient and attenders were explained about the nature of disease, risks and prognosis of CAD and the need for revascularization. Currently, he is getting admitted for the same. No H/O Breathlessness, Palpitations, Syncope or Swelling of Legs.

No H/O CVA, CKD, BA, seizure disorder or Hypothyroidism

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

NAME: MR. SOMASUNDARAM

TEMP

96.4° F

HR

72bpm

BP

130/78 mmHg

SPO₂

98% in room air

CVS

S1S2 (+)

RS

BAE (+)

Abdomen

Soft, non - tender

CNS

NFND

BLOOD INVESTIGATIONS:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN		Male: 13.7 - 17.5	gms%
	12.4	Female: 11.2 - 15.7	
HAEMATOCRIT	38.2	39-52	%_
TWBC	7270	4000 - 10000	Cells/Cumm
POLYMORPHS	57.0	40-70	%
LYMPHOCYTES	25.3	20 - 40	%
EOSINOPHILS	4.9	0 - 6	%
PLATELET	325000	Male: 1.5 - 3.5	Lakhs/cumm
		Female: 1.5 - 3.7	
Urea	11.6	14 - 40	mgs/dl
Creatinine	0.65	Male: 0.7 - 1.2	mgs/dl
		Female: 0.5 - 1.0	
		Child: 0.2 - 0.8	
Sodium (Na+)	139	135 - 145	mmol/l
Potassium (K+)	4.19	3.4 - 5.5	mmol/l
T. Bilirubin	0.315	0.2-1.0	mg/dl
D. Bilirubin	0.137	0.00 - 0.4	mg/dl
I. Bilirubin	0.177	0.4-0.6	mg/dl
S.G.O.T	23	<38	U/L
S.G.P.T	19	<41	U/L
ALP	110	Adult: 42 - 141	U/L

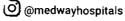
# 9	, Tst Main Road, United India Col	ony, Kodambakkam, Chennai	- 600024. Tel: 044 - 4310 8959



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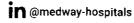
Kodambakkam

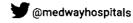
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Kumbakonam

044-2473 4455





044 - 4310 8959



Medway Group of Hospitals

Chengalpattu Viilupuram 044-27426829 04146-242000

Medway Centre of Excellence (Chennai)

Heart Institute Institute of Pulmonology

044-2473 4454



NAME: MR. SOMASUNDARAM



Every heart beat counts

(A Unit of United Alliance Healthcare Pvt Ltd)

UHID: MHI202379692 IPNO: IPH202302190

PROTHROMBIN TIME	0.9	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 -	
	1	4.5 Recur, Systmic Embolism: 3.0 - 4.5 INR	
НВАІС	8.9	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	1.055	Adult: 0.25 - 5.0 New born-4days: 1.0-39.0 Child upto 14yrs: 1.0-9.0	ulU/ml
Т3		"Adult: 60 - 152 New born - 4 days: 96 - 730 1 - 11 Months: 102 - 243 1 - 9 yrs: 89 - 237	ug/dl
T4	1.01	"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: 72bpm, sinus rhythm, ST depression in lateral leads

ECHO: MILD CONCENTRIC LVH, NO REGIONAL WALL MOTION ABNORMALITY. NORMAL LV FUNCTION - EF: 60 %, NORMAL RV FUNCTION, RV TDI: 12CM/S, TAPSE: 24MM, ALL VALVES ARE STRUCTURALLY NORMAL, IAS / IVS INTACT, IVC NORMAL IN SIZE AND COLLAPSING, TRIVIAL MR, TRIVIAL TR, NO PAH, NO CLOT / VEGETATION / **EFFUSION**

CXR: PA film, lung Fields clear.

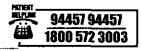
#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel: 044 - 4310 8959 **★** @MedwayHospitals

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044-26530011

Medway Centre of Excellence (Chennai)

044-2473 4455





(A Unit of United Alliance Healthcare Pvt Ltd)

UHID: MHI202379692 IPNO: IPH202302190

COURSE IN THE HOSPITAL:

NAME: MR. SOMASUNDARAM

Mr. Somasundaram.M, 47 years old male, was admitted with above mentioned complaints. He underwent OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 2 GRAFTS: LIMA TO LAD, LEFT RADIAL ARTERY TO OM ON 06.11.2023. He was extubated on table in Operation theatre. He was shifted to SICU with stable hemodynamics and nil supports. Drains were removed on POD1 (07/11/2023). He was shifted to ward on POD 2 (08/11/2023). Suture removal was done on POD 3 (09/11/2023). 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 - 106/min BP - 130/80mmHg

SPO2 - 94% in room air

POST OP INVESTIGATIONS:

BLOOD:

Test Name	Result	Reference Value	Units
HAEMOGLOBIN		Male: 13.7 - 17.5	gms%
	11.4	Female: 11.2 - 15.7	
Urea		14 - 40	mgs/dl
	32		
Creatinine	0.55	Male: 0.7 - 1.2	mgs/dl
		Female: 0.5 - 1.0	
		Child: 0.2 - 0.8	
Sodium (Na+)	135	135 - 145	mmol/l
Potassium (K+)	4.21	3.4 - 5.5	mmol/l

ECG: HR – 96 bpm, Sinus rhythm, Q wave in inferior leads

ECHO: S/P CABG, ALL CHAMBERS NORMAL IN SIZED, NO REGIONAL WALL MOTION ABNORMALITY, NORMAL LV SYSTOLIC FUNCTION – EF: 60%, NORMAL RV SYSTOLIC FUNCTION, RV TDI: 10CM/S, TAPSE: 17MM, ALL VALVES STRUCTURALLY NORMAL, IAS / IVS INTACT, IVC NORMAL IN SIZE AND COLLAPSING, AORTIC GRADIENT – MAX GRADIENT – 14 MM HG, MEAN GRADIENT – 8 MM HG, TRIVIAL MR, MILD TR, MILD PAH, MILD PERICARDIAL EFFUSION BEHIND RA, MEASURES: 10MM, TRACE PERICARDIAL EFFUSION POSTEROLATERAL TO IV, MILD BILATERAL PLEURAL EFFUSION, NO CLOT / VEGETATION.

CXR: PA film, sternal wires seen, lung fields clear, CTR:0.55 %, minimal bilateral pleural effusion.

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	Med	way Group of Hos	pitals		Medway Centre of Exc	cellence (Chennai)
Kodambakkam 044-2473 4455	Mogappair 044-2653001	1	Chengalpattu 044-27426829	Villupuram 04146-242000	Heart Institute 044 - 4310 8959	Institute of Pulmonology 044-2473 4454
:-mail : info@med	wavhospitals.co	n Website : www.me	edwayhospitals.com i	LCIN : U74900TN20	11PTC083665	MHI/HOSP/2022/118





(A Unit of United Alliance Healthcare Pvt Ltd) IPNO: IPH202302190

NAME: MR. SOMASUNDARAM

ADVICE MEDICATIONS:

Sl	NAME OF THE DRUGS	STRENGTH	DOSAGE	FRE	QUEN	CY	ROUTE	RELATIONSH IP WITH	DURATION	
NO.	WITH GENERIC NAME	SIKENGIH	DUSAGE	M	A	N	ROUTE	MEAL	DURATION	
1	TAB. CLOPITAB A (CLOPIDOGREL + ASPIRIN)	I TABLET	75MG / 75MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE	
2	TAB. ROSUVAS (ROSUVASTATIN)	1 TABLET	40MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE	
3	TAB. DILZEM – SR (DILTIAZEM)	1 TABLET	90MG	1	0	1	ORAL	AFTER FOOD	X 6 WEEKS	
4	TAB. BETALOC (METOPROLOL)	1 TABLET	25MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE	
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)	
. 7	SYP. CREMAFFIN PLUS (SODIUM PICOSULFATE+ LIQUID PARAFFIN + MILK OF MAGNESIA)	15ML		0	0	1	ORAL	AFTER FOOD	BED TIME (IF CONSTIPATI ON)	
8	TAB. BEPLEX FORTE (ANTIOXIDANTS +MULTIVITAMINS+ MULTIMINERALS)	1 TABLET		1	0	0	ORAL	AFTER FOOD	I MONTH	
9	SYP ALEX PLUS (DEXTROMETHORPHA N HYDROBROMIDE + GUAIFENESIN + PHENYLEPHRINE + CHLORPHENIRAMINE MALEATE)	10ML		0	0	1	ORAL	AFTER FOOD	BED TIME (1 WEEK)	
10	TAB.ANXIT (ALPRAZOLAM)	1 TABLET	0.25MG	0	0	1	ORAL	AFTER FOOD	X 5 DAYS	

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Medway Centre of Excellence (Chennai)

044-2473 4455





(A Unit of United Alliance Healthcare Pvt Ltd)

UHID: MHI202379692 IPNO: IPH202302190

NAME: MR. SOMASUNDARAM

DIABETIC MEDICATIONS:

St.	NAME OF THE DRUGS	STRENGTH	DOSAGE	FR	EQUE!	NCY	ROUTE	RELATIONSHIP	DURATION
NO	WITH GENERIC NAME			М	A	N		WITH MEAL	
1	TAB.METFORMIN	500MG	1 TABLET	l	0	ı	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. GLIMEPRIDE	2 MG	1 TABLET	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
3	INJ. HUMAN INSULIN (RECOMBINANT HUMAN MONOCOMPONENT INSULIN)			6U	0	6U			TO CONTINUE
4	INJ. NPH (ISOPHANE INSULIN)			6U	0	6 Ú			TO CONTINUE

DISCH	DISCHARGE ADVICE				
DIET	HIGH PROTEIN, LOW SALT				
	LOW FAT DIET.				
PHYSICAL ACTIVITIES	RESTRICTED.				
FLUID RESTRICTION	NIL				
	TO DO FBS, PPBS, HB, UREA,				
REVIEW	CREATININE, SODIUM, POTASSIUM,				
	CHEST X RAY IN ESI HOSPITAL ON				
	20/11/2023 AND REVIEW WITH				
	REPORTS				

To report: If fever> 101 'F / Difficulty in breathing / Headache / Giddiness/chest pain/ Groin swelling/bleeding / discharge at operated site/ Any other significant symptoms.

In case of emergency Contact: Medway Hospitals @ 044 -43108959.

Typed by: Kalai

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Dr. V. RAJESH

Dr. V. Rajesh, MS, M.Ch (CTVS) Senior Consultant Cardiothoracic and Vascular Surgery

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Kodambakkam Chengalpattu Villupuram 044-2473 4455 044-26530011 044-2473 4455 | 044-27426829 04146-242000 E-mail: info@medwayhospitals.com | Website: www.medwayhospitals.com | CIN: U74900TN2011PTC083665 Institute of Pulmonology 044-2473 4454

MHI/HOSP/2022/118



Pa Mr.SOMASUNDARAM M
Nz 47/Malc/MHI202379692
Ul 05/11/2023/IPH202302190
Dt Dr.RAJESH.V
Dt Ct



INPATIENT INITIAL ASSESSMENT

Date: 5/11/23 Time of arrival in ward: 11.00
Allergies (if Yes, specify details):
Drugs
Blood Transfusion
Food
Others
Vital Signs: Temp: <u>96 4</u> (°F) Pulse / HR: <u>72</u> (beats/min) BP: <u>190 احدا</u> (mmHg)
Respiration: (breaths/min) SpO ₂ : 98 (%) Height: 18 (cms) Weight: 69 × (kgs) BMI: 27-7 kg/m2
Pain: Yes No. If Yes, Score: 6/10 Pain Scale Used: Numerical Rating Scale (>12 years) CPOT (ventilator / comatose)
Duration: Location: Locati
Pain Character: Dull Aching Sharp Stabbing Shooting Burning Referred / Radiant Pain
CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS
At come in i HIs- Shoulder pour @ Jan pour and (sided.
Chut pain on 18/9/23, Southt Comult at ESIC nospidal and was breated. Conservatively, It was collised CAG and was referred to with and, was dan an 125/9/23) revale DVD, and have It was addition for
Conservatively, It was calmised CAG and was referred to WMHE and
not dan an 125/9(23) revale DVD, and have It was addited for
(M 9 h
PAST MEDICAL HISTORY (with duration of illness):
Diabetes Mellitus: ☑Yes ☐No. If Yes, duration: ፲፰፻٠٠ Hypertension: ☑Yes ☐No. If Yes, duration: ፲፰፻٠٠
Others:
Past Surgical History:
HILO- Heramurrhaidedon 2003

S. O.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
)	ing Robuler muin	4011/21	5/2	6-0-6 um	5/4/23	ØYes □ No
<i>y</i>	ing NP4.	4.11/_	S) c	6-6-6-12	5/4/23	[]∕Yes [] No
<u>3</u>)	T-WINTED	2.6~	0 cm	1-61	Slulzz	[⊒Yes ☐ No
	T-PAN	404	Plo	·~~	5/11/23	☐ Yes ☐ No
ij	I-welleswith	5004	Pa	1-01	5)4123	☑ Yes ☐ No
	T-Glimeprids	1-7	010	1-01.	3/4/23	☐ Yes ☐ No
/	E-zim witamin cap	1cm	P 64	, 6-0	5/11/23	☑ Yes ☐ No
)	T-COPIDOGREL	35745	Pho	0-1-0	31/10/23	☐ Yes ☑ No
3)	T-FWIPRIM	25mg	14	0-1-	31/10/23	☐ Yes ☐ No
-+					· · · · · ·	
	ly History:	cast	- February	0.0-1	4/11/23.	∏Yes □ No
Pers Life	sonal / Social History (Tick whitestyle: Sedentary	chever is an	~ Fc√√	Recreationa		
Pers Life Sm	sonal / Social History (Tick whitestyle: Sedentary	CAXt	~ Fc√√	Recreationa	¥ \	
Pers Life Smo	sonal / Social History (<i>Tick whit</i> estyle: ☐ Sedentary ☐ Active oking: ☐ Yes ☑ No Alcoh	chever is ap	oplicable) ation: No 17/9(23)	Recreationa		
Pers Life Smo	sonal / Social History (Tick whitestyle: Sedentary Active oking: Yes No Alcohorers: strual and Obstetric History (to	chever is ape Occup ool: Yes o be filled up	oplicable) ation: No 13/9(23)	Recreationa		No

SYSTEMIC EXAMINATION
cvs:
3118
Respiratory System:
SAEB
Gastrointestinal System:
SUD- 124
Central Nervous System:
Urinary / Reproductive / Locomotor System:
Offiliary / 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 No Is the patient severely ill? (e.g. in Intensive Therapy) Yes No
Reduced dietary intake in the last week? ☐ Yes ☐ No Is the BMI < 20.5? ☐ Yes ☐ No
Interpretation: Yes: If the answer is "YES" to any 2 questions, the patient is at nutritional risk No: If the answer is "NO" to all questions, the patient is at Normal and not at risk
Provisional Diagnosis:
CAD-crisical Lex-major om + Bodeline LAD /74-II-DM/ STITM. MILV.
Plan of Care: Admit pr it Dr. Rojesh.
Plant chish - Tommon - Plant chish - Tommon
Plan of Care: Admit pr it Dr. Rojesh. Plan: chish - Tomorrow To get anothetic Filmer.

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Investigations Ad	lvised:	·				•		
	Reputs	endort.						
Diet Advice:								
☐ Nil per Oral	Clear liquid diet	☐ Normal liquid	d diet	Diabetic	liquid diet			
Semisolid diet	et Soft solid diet South Indian normal diet North Indian normal diet							
Neutropenic liquid	☐ Neutropenic liquid diet ☐ Others:							
Early Discharge Plan	ning (fill in those which are a	appropriate at this	s stage):	PFE: Pa	tient Family E	ducation		
Special support need	ed at home	∠ Yes □ No	If Yes, PFE	done				
Home equipment anti	cipated	∐Yes □ No	If Yes, PFE done and equipment advised					
Physiotherapy at hom	ne anticipated	∠ Yes □ No	If Yes, edu	Yes, educated on physical limitations, if any				
Wound care needs ar	nticipated at home	☐ Yes ☐ No	If Yes, edu	cated on signs	on infection			
Pain Management		. Yes □ No	If Yes, PFE	done and med	dication advis	sed		
Special Dietary needs	5	⊉ Yes □ No		icated on dietar actions and alle		i, food		
Continuous / ongoing	g care anticipated	☑Yes ☐ No	If Yes, educated on various aspects of ongoing care required					
Other special education	on need, i.e.:	1 Yes □ No	If Yes, PFE	E done				
Nature of post hospita infection control, fall r	al needs like patient safety, isk, etc, addressed	☑ Yes □ No	If Yes, spe	cific education	given			
Others:								
	Dr. V. RAJESH							
	Signature Ch(CTVS)	Name		Reg. No.	Date	Time		
Resident Doctor ^{Car}	diothoracle and Vascular Sur	gery Dr. Djag		16326)	5 11/2/3	11.00		
Consultant	V lugar 62794	DR. RAJ	ESH ·	62794	05/11/23	14:00		
Patient Attendant	· 18001	Relationship			11/2	11.00		

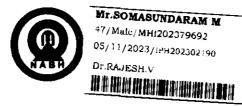
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Heart
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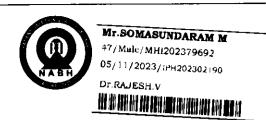
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(A Unit of United All	Bence Heelthcara Pvt Ltd)		71.7 1986 184 (17112 1866 41) (1 1814 11)	my heart best co	unts
	DOCTOR'S	PROGRESS NO	OTES		
DATE		NOTES			
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@14:50	Mr. Somarundaram	to sue z	foll. Ben	adynamiy	
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	BP 131/78 ny				
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	Support Nil.				
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DATE	NOTES
07/11/2023 @ 8:30	els: pr. Anharaeu los Rajest los pravoca lor-jai
<u>.</u>	SIP: OPEAB X 2 grafts.
Coppii	· patient comportable
HB -	Olf: conscious, priented. Afebrôk
<u>u -</u>	· BP-136/84 months
2x -	· HR-104 Bpm
<u>ma - 136</u>	Spo BR x. or goon air
K - 4.18	. 210 - 231,9 ml 12198 ml ; Bal HISTML
	· On ucath
RBS - 180 mg	de Adequate wine output
	Dereating feeds
OB4	· poriphoxies felt warm(t)
PH - T. 410	
PC02-39-4	SUPPORTS: NIL
po 66.4	rotaldrain: 470mL
4100-24-4	<u>plao</u>
BF - (-)0.2	· RF - 2. by litter Iday
	Good chest physic
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	DOCTOR'S PROGRESS NOTES
DATE	NOTES
Blulzons	SB: Dr. enhavasu Ipr. eajest br. praveen
6 8:30	· · · · · · · · · · · · · · · · · · ·
	SIP: OPLAB X 2
ponts_	· patient comportable
b - 11.4	OlE: conscious, oriented, Alebrile
- 33	RP - 120 /78 mmHg
2 - 0.55	. HR - 104 Bpm
ra - 135	·SPO 904. on soom ais
< - 4.21	1910 - 234/ml /22 poml ; Bal +39/ml
	· u cath romoved
RBs - (20 mg	lde . sedfroided - soome
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<u> </u>	plan:
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	,
	for X- Xelvo
	Dr. Anharasu wolfs
	pa. Kartaita (nH10216)
	- Land

DATE	N	OTES	
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8/11/23			
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Mr.SOMASUNDARAM M

47/Male/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V





OGRESS NOTES NOTES On gian (Dmo) A reviewed. OPCAS x2 graft (PCD - Till) o hew complaints of prelent:
on gay (Dmo) 14 reviewed. OPCAS x2 graft (PCD - Till) o new complaints of prelent:
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-Inform (105)
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DATE	NOTES
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alulas	clash D. Amarech (Dina)
9:15 pm	
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	POD III OPCAR - > grafte
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	ple - pt concion, oriented, oriented.
<u> </u>	NET CUS JOVAD
	Flo-reft, RSD.
············	advice
 	
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	took or per chat
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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

	MI. SOMASUNDARAM M PRE-OPERATIVE CHECKLIST		
Name :	47/Male/MHI202379692 05/11/2023/⊮H202302190 Age : ☐ Gender : M UHII	D No.: 20,	2379692
Ward:	Bed No.: G.w-1	B.S.	A.S.
	Clinical Diagnosis: CORONARY ARTERY DISEASE - CRITICAL LCX DOUBLE VESSEL DISEASE		
	Proposed Procedure: CORONARY ARTERY BYPASS GRAFT	J.	
	CHECKLIST		
1.	Identification Band on Hand Checked ?		
2.	Surgical consent Signed? a. Special Consent signed if required.		
3.	Anesthetist Consultation (If required?)		
4.	a. Height 58 Cm b. Weight 69.25 kg		
5.	Allergic to drugs? NKDP	~	
6.	Surgical Preparation done ?		
7.	Nill by Mouth From		
8.	Blood Grouping & Rh Typing		
9.	Investigation X - Ray Ray AB		
10.	Blood Sugar 169 Time 5.50		
11.	TPR Chart Pulse 92 bm Temp 98 F BP 154112 RR 206M		
12.	Time Voided a. Retention No		
13.	Enema Yes No		

14.	a. Prosthesis Removed		
15.	Valuables and Jewellery Removed ☐ Yes ☐ No Secured ☐ Yes ☐ No	>	<u>/</u> .
16.	a. Time b. Nurse	\	
17.	Blood Transfusion requisition Onchart	\ \	/
18.	X-Ray No	~	
_	ECG / ECHO		
- ' '	Ultra Sound	·	
	C.T. Scan		
	MRI Scan		
	TMT		
	Medication		
5/11/3	3 T. PAN AOMG Pawen @ 21.00		/
	T. ALPRAX 0.25 mg		
bluks			
	Di Maephre 5 mg) Di Chaneegan 12.5 mg JM grown		
	The state of the s		5
	Others		

F. Office of Nurse Signature



Mr.SOMASUNDARAM M

47/Male/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V





SIGNATURE: July. m

PA. Kaoutuika

(MHT0216)

MEDWAY HOSPITALS CARDIAC SURGICAL CHECK LIST

Name Mr. Soma sundaram	Age 37 m UHID MH1202377692
Diagnosis CAD - critical sex + Dro, Bordenline LAD Good en function, Ef-box.	Plan CABY
Non- reactive	
EURO Score / STS Score O 、55 ン	PRE OP DRUGS (ACE/ARB/ANTIPLATELETS): عام المارة ا
Diabetes Mellitus (HB1AC) & 9 %	Associated Illness T2 DM, HTN
Carotid Doppler +	Thyroid Enzymes Ty-1.01 TsH-1.05
Sr. Creatinine 0.65 mgldL	Any other illness of concern —
Allen's Test (+ ve)	Myocardial viability if needed
Varicose Veins	
Pulmonologist Clearance -	Nephro Clearance:
Neurology Clearance :	Dental Clearance:
Mitral Regurgitation Assessment Trivial MR	INO PAH
Nursing:	Billing Clearance: ✓
Physiotherapy	Spirometry taught
Concerns from Surgical Team :	





MEDWAY HOSPITALS CARDIAC SURGICAL CHECK LIST

Name MR.Soma	es undatarn.m.	Age	UHID
Diagnosis		Plan	
Serology			
EURO Score / STS Sc	ore	PRE OP DRUGS (ACE/ARB/	ANTIPLATELETS):
Diabetes Mellitus (HB	1AC)	Associated Illness	
Carotid Doppler		Thyroid Enzymes	
Sr. Creatinine		Any other illness of concern	
Allen's Test		Myocardial viability if neede	d
Varicose Veins			
Pulmonologist Cleara	nce	Nephro Clearance:	
Neurology Clearance	:	Dental Clearance:	
Mitral Regurgitation A	ssessment		
Nursing:		Billing Clearance:	
Physiotherapy		Spirometry taught	
Concerns from Surgic	al Team :	SIGNATURE :	

MR. Somascundasam in UT/M TYPE 11 DM, systemic hylvertension.

ACS-NSTMI, CAD-TVD Normal Lu systolic limetion as come for.

CABLIN. patient was approantely normal till 2 months ago. When he author cleveloped Reliasternal cheet pain cradialing to hadren necknowledges.

1.11 Industrially went to that harmon kir nage test hospital where he draghosed as ACS-INSTEMI he was advised for early CAU. He came to medway hospital on 25/09/2023 he under the CAU on asked same day which showed as CAD-DVID...

111 was advised for CABLING MULTINESSEE PCIIDED







47/Male/MHI202379692

05/11/2023/IPH202302190

Dr.RAJESH.V

CONSENT FOR SURGERY

1.	Mr./ Ms./Mr sSaทภมหา Daหลท
tici	k correct option and below):
	☑ Read
	☑ I/We have been explained the current clinical condition of me/my patient
	Been explained this consent form in English, which I fully understand and understood the information
	provided about the diseaseCORQUARYARTERY DUEAGE / POUBLE XELLELDIS.EASE. and about the
	procedureCARANARYARTERYRYMASSGRAETING(full name of operation / procedure given below in this consent form)
•	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 writing.

- I am aware that I may require administration of blood and / or blood products during or after the operation / procedure as found necessary by the doctor (for which a separate consent shall be obtained).
- I am now also aware that during the course of this operation /procedure the doctor will be assisted by medical and paramedical team and that the doctor may seek consultation / assistance from relevant specialists if the need arises.
- 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 1. Bleeding 2. The	Tion 3. Shake	
4: Prolonged 100 stay 5: Hild risk to life		-
Benefits Sumptom free Sumuch		
• Alternatives Agh risk PTCA		
The likelihood of success of the surgery (Percentage / Other commands)	964.	
• Possible results of non-treatment 1 Hungardial Industria		

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.

2. Heart Failure.

DETAILS	PATIENT / RELATIVES	WITNESS
Name (in BLOCK LETTER)	MR. SOMA SUNDARAM	HRS. MEENA
Relationship	5ELF	WIFE
Signature	-mGdn-620325	. 15°0017
Date & Time	5/11/23 @ 1500	5/11/23@ 15.00
Name & Signature of Doctor with Registration No.: Dr. PRAYEEN TEYAKUMAR		

M.S. M.Ch(CTVS)
Senior Consultant
Cardiothoracic and Vascular Surgery
Peg No: 6270:

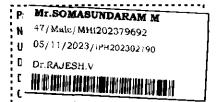
M.S. M.Ch(CTVS)
Senior Consultant

Cardiothoracic and Vascular Surgery

Peg No: 6270:

Doctor Seal







CONSENT FOR ANAESTHESIA SERVICES

MR. Somesund ARAm The patient or the representative of patient have,					
(please tick the correct option above and below) Read					
✓1/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					
Operation/Procedure		, which is a second and a second and a second as a			
(DROMARY) AKTERY BYPACS GRAFTIMS					
(full name of operation / procedure given below in this consent form)					
 My surgeon has explained the risks of the procedure and has advised me of alternative treatments and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anaesthesia services are needed for this operation, so that my doctor can perform the operation or procedure. It has been explained to me that all forms of anaesthesia involve some risks. Although rare, unexpected severe complications with anaesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of anaesthesia and that additional or specific risks have been identified below, as they may apply to a specific type of anaesthesia. I understand that the type(s) of anaesthesia service checked below will be used for my procedure and that the anaesthetic technique to be used is determined by many factors including my / my relative's physical condition, the type of procedure, my doctor's preferences, as well as my own desire. It has been explained to me that sometimes an anaesthetic technique which involves the use of local anaesthesia, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anaesthesia. It has been may be needed explained to me that the following may be needed as part of anaesthesia during or after surgery Central Venous catheter Arterial Line Lumbar Puncture Tracheostomy Transesophageal Blood & Blood product Transfusion Old Admission / Recovery Others 					
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			
		- Relief of Anxiety			
Spinal or Epidural Analgesia / Anaesthesia	Expected Results	Temporary decreased or loss of feeling and / or movement in the lower half of the body			
☐ With Sedation / GA ☐ Without Sedation Alternatives	Technique	Drug injected through a needle / catheter placed either directly into the spinal canal or immediately outside the spinal canal			
GA Others	Risks	Nerve damage, persistent back pain, headache, infection, convulsions, bleeding / hematoma, toxicity due to local anaesthetic, chronic pain, medical necessity to convert to general anaesthesia, brain damage			
/	Benefits	Post-operative pain relief with epidural catheter that can be left in-situ safer under certain conditions			
Major / Minor Nerve Block	Expected Results	Temporary loss of feeling and / or movement of a specific limb or area			
☐ With Sedation / GA☐ Without Sedation	Technique	Drug injected near nerves providing loss of sensation to the area of the operation			
Alternatives ☐ GA	Risks	Nerve damage, persistent pain, infection, bleeding / hematoma, toxicity due to focal anaesthetic, medical necessity to convert to general anaesthesia, brain damage			
☐ IV Regional Anaesthesia☐ Spinal/Epidural Anesathesia☐ Others	Benefits	- Pain Free - Safer under certain conditions			

☐ Intravenous Regional Anaesthesia ☐ With Sedation / GA ☐ Without Sedation		Expected Results	Temporary loss of feeling and / or movement of a limb				-	
		Technique	Drug injected into veins of arm or leg while using a tourniquet					
Alternatives	or Nonco Plac	ماد	Risks	Infection,	convulsions, persiste	ent numbness residual	pain, injury to blood	vessels
☐ Major/Mind ☐ GA	or incree bloc	UK.	Banafita	- Pain Free				
☐ Others		Benefits	- Safer und	der certain conditions	5			
Monitored Anaesthesia care		Expected Results	Decreased anxiety and light sedation similar to normal sleep					
(with sedation) Alternatives ☐ General anaesthesia ☐ Spinal / Epidural ☐ Others		Technique	Drug injected into vein of arm					
		Risks	Prolonged sedation, need for airway control					
		Benefits	Anxiety free; Early discharge					
			Expected Results	No observation to the survey of the survey o				
(without sedation	(without sedation)		<u> </u>	No changes in the system				
Alternatives ☐ General ana	poethocia		Technique	None				
Mild Sedation			Risks	Patient may have pain and anxiety				
☐ Others			Benefits	Early disc	narge ————————————	 -	<u> </u>	
Potential I anaesthes I, the above the date of the above carrying out the risks and com I, the above necessity.	ong term ne sia/modera re named Pa f signing this e mentioned he said oper aplications, i	egative ef te sedatic atient / nai s form, me operation ration / pro intended I	on / deep sedation of med patient's repre- entally sound and a n(s) / procedure(s) ocedure on mys benefits and possib	during pregresentative, com giving contact I have to self or my pole alternative, do fu	nancy and in early of further hereby do further hereby do nsent without any force made aware of above named patives.	eclare that I am abo ear, threat or false m of, I give my consent ient being fully awar are that I am about 1	ve 18 years of age hisconception t voluntarily to doo e of the nature, po	e as on stor for tential
date of signin			sound and am givin		vithout any fear, thre	eat or false misconc	eption. Date	Time
Patient	Patient				MR. SOMA SUNDARAM		5/11/23	15.00
	m.E.an		-30 205					·——
Surrogate/Guardian (if applicable #)		TT	(Write	MAS. MEENA (WIFE) (Write name and relationship with patient)		5/11/23	15:00	
Reason for	Patie	ent is una	able to give cons	ent because	e:			
surrogate conse	ent							ſ
Witness 5 ·		Dy 0212	5.	5. DEVADHARSHINI		5/11/23	1500	
Interpreter (if applicable)								
procedure co	igned docto			re, potential		cations, intended b	enefits, expected	
Signature		ossible a	Iternatives to the p ood the information					
	the/sheha	ossible a s underst	ood the information	n fully as des	scribed in this docu	ment.		
Consent obtained by		ossible a s underst	ood the information	n fully as des	scribed in this docu		ent representativ	e. I am



-	நோயானி விவரங்க	ள் : (Affix Label here)
•	பெயர் :	
	UHID:	
:	பிறந்த தேதி:	பாலினம்:
i	சோக்கை தேதி:	
i	மாத்துவர்:	



<u>மயக்க மருந்து சேவைகளுக்கான ஒப்புதல்</u>

மேலேயும் கீழேயும் சரியான விருப்பத்தைத் தேர்ந்தெடுங்கள்) படித்தல் என்னை / என் நோயாளியின் தற்போதைய மருத்துவ நிலை குறித்து விளக்கப்பட்டுள்ளோம். ஆங்கிலத்தில் இந்த ஒப்புதல் படில விளக்கப்பட்டுள்ளது. இது வழங்கப்பட்ட தகவல்களை நான் முழுமையாக புரிந்துகொண்டேன். செயல்பாடு / செயல்முறை
இந்த ஒப்புதல் படிவத்தின் கீழே கொடுக்கப்பட்ட செயல்பாட்டு நடைமுறையின் முழு பெயரி
 எனது அறுவை சிகிச்சை நிபுணர் நடைமுறையின் அபாயங்களை விளக்கியுள்ளார் மற்றும் மாற்று கிகிச்சைகளுக்கு எனக்கு அறிவுறுத்தியுள்ளார் மற்று எதிர்பார்க்கப்பட்ட முடிவைப் பற்றி என்னிடம் கூறினார். எனது நிலை சிகிச்சையளிக்கப்படாவிட்டால் என்ன நடக்கும். இந்த செயல்பாட்டிற்கு மயக்க மருர சேவைகள் தேவை என்பதையும் நான் புரிந்து கொள்கிறேன். இதனால் எனது மருத்துவர் அறுவை சிகிச்சை அல்லது செயல்முறையைச் செய்ய முடியும்.
 அனைத்து வகையான மயக்க மருந்துகளும் சில அபாயங்களை உள்ளடக்கியதாக எனக்கு விளக்கப்பட்டுள்ளது. மயக்க மருந்துகளுடன் எதிர்பாற கடுமையான சிக்கல்கள் ஏற்படலாம். தொற்று நோய், இரத்தப்போக்கு, போதைப்பொருள் எதிர்வினைகள், இரத்த உறைதல், உணர்வு இழப்பு, மூ செயல்பாடு, பக்கவாதம், மூளை பாதிப்பு அல்லது மரணம் போன்ற தொலைதூர சாத்தியங்களை உள்ளடக்கியிருக்கலாம்.
இந்த அபாயங்களை அனைத்து வகையான மயக்க மருந்துகளுக்கும் பொருந்தும் என்பதையும் கூடுதல் அல்லது குறிப்பிட்ட அபாயங்கள் கீ அடையாளம் காணப்பட்டுள்ளன என்பதையும் நான் புரிந்து கொள்கிறேன். ஏனெனில் அவை ஒரு குறிப்பிட்ட வகை மயக்க மருந்து விண்ணப்பிக்கலாம். கீழே சரிபார்க்கப்பட்ட மயக்க மருந்து சேவையின் வகை (கள்) எனது நடைமுறைக்கு பயன்படுத்தப்படும். மயக்க மருந்து நுட்பம் என உறவினர் உடல்நிலை, எனது மருத்துவரின் விருப்பங்கள் மற்றும் எனது சொந்த விருப்பம் உள்ளிட்ட பல காரணிகளால் தீர்மானிக்கப்படுகிறது என்பக நான் புரிந்து கொள்கிறேன்.
* சில நேரங்களில் உள்ளூர் மயக்க மருந்துகளைப் பயன்படுத்துவதை உள்ளடக்கிய ஒரு மயக்க மருந்து தொழில் நுட்பத்தை, மயக்க மருந்து இல்லாய முமுமையாகப் பெறாமல், மற்றொரு நுட்பத்தை மயக்க மருந்து உட்பட பயன்படுத்த வேண்டியிருக்கும் என்று எனக்கு விளக்கப்பட்டுள்ளது.
எதிர்பார்க்கப்படும் காற்றுப்பாதையை பராமரிக்க ஒரு குழாயை காற்றாலையில் அமர்த்துவதை உள்ளடக்கிய பொது மயக்க மருந்து முடிவுகள் மொத்த மயக்க நிலை
மாற்று மருந்து நுட்டம் இரத்த ஓட்டத்தீல் செலுத்தப்படும் மருந்து, நுரையீரலில் சுவாசித்து அல்லது பிற வழிகள் வழங்கப்படுகின்றன
மற்றவை
முதுகெலும்பு அல்லது எதீர்பார்க்கப்படும் உடலின் கீழ்பாதியில் உணர்வு அல்லது இயக்கத்தின் தற்காலிக குறைவு அல்லது இழப்பு
மயக்க மருந்து / பொது மயக்க மருந்துநுட்பம்
பயக்க மருந்து இல்லாமல் எலும்பு சேதம், தொடர்ச்சியான முதுகுவலி, தலைவலி, தொற்று, இரத்தப்போக்கு, இரத்தம்பே நெற்று மருந்து பாற்று மருந்து மாற்று மருத்துவ சேவை காரணமாக நச்சுத்தன்மை
பெரிய / சிறிய நரம்புத் தொகுதி எதிப்பார்க்கப்படும் மயக்க மருந்துடன் / பொது மயக்க மருந்து முடிவுகள்
ு மயக்க மருந்து இல்லாமல் நுட்பம் செயல்பாட்டின் பகுதிக்கு உணர்வு இழப்பை வழங்கும் நரம்புகளுக்கு அருகில் மருந்து நாற்று மருந்து
் பொது மயக்க மருந்து அபாயங்கள் அபாயங்கள் அபாயங்கள் கூறும்பு சேதம். தொடர்ச்சியான வலி, தொற்று, இரத்தப்போக்கு, ஹெமடோமா, உள்ளூர் மயக் மருந்து, மருத்துவ சேவை காரணமாக நச்சுத்தன்மை, மயக்க மருந்து, மூளை சேதத்திற்கு மா

நரம்பு மண்டலம் மயக்க மருந்து		எதிர்பார்க்கப்படும் முழுவுகள்		உணர்வு மற்றும் ஒரு குறிப்பிட்ட மூட்டு இயக்கத்தீன் தற்காலிக இழப்பு				
🗌 மயக்க மரு	□ மயக்க மருந்து□ மயக்க மருந்து இல்லாமல்		+	ஒரு டூர்னிக்கேயைப் பயன்படுத்தும் போது கை அல்லது கை நரம்புகளில் செலுத்தப்படுகிறது				
மாற்றுகள் 🗖 பெரிய / சிறிய நரம்பு தொகுதி		அபாயங்கள்		தொற்று. வலிப்பு, தொடர்ச்சியான உணர்வின்மை, மீதமுள்ள வலி, இரத்த காயங்களுக்கு காயம்				
	பாதுவான மயக்க மருந்து		+	– வலி இலவசம்				
🗌 மற்றவை	🗌 ഗற்றகைவ		– சில	– சில நிபந்தனைகளின் கீழ் பாதுகாப்பானவை				
(மயக்கத்துடன்)	கண்காணித்த மயக்க மருந்து கவனிப்பு (மயக்கத்துடன்) மாற்றுகள்		<u> </u>	சாதாரண தூக்கத்தைப்போன்ற கவலையும் ஒளியும் குறைந்து வருகிறது				
			கையி	கையின் நரம்பில் மருந்து செலுத்தப்படுகிறது				
		அபாயங்கள்	நீண்ட	நீண்ட கால மயக்கம், காற்றுப்பாதை கட்டுப்பாடு தேவை				
🗌 மற்றவை	🗌 மற்றவை		கவை	கவலை இலவசம், ஆரம்ப கால வெளியேற்றம்				
மயக்கம் இல்லா				கணினியில் மாற்றங்கள் இல்லை				
			இல்ல	இல்லை				
_ ~			நோய	நோயாளிக்கு வலி மற்றும் கவலை இருக்கலாம்				
🗌 ഥற்றவை		நன்மைகள்	ஆரம்	ப வெளியேற்றம்				
பருவத்தில் ஆ * நான் / மேற்க பயமும் இல்ல மேற்கூறிய செயல் டாக்டர் (டாக்டர்) டி. நோயாளியிடம் முடு நான் / மேற்கூறிய	தழமான மயக்கத்துடன் நீ கூறிய நோயாளி / பெயரி லாமல் ஒப்புதல் அளிக்கீழே வாட்டிற்கு (எஸ்) / நடைமும அல்லது டி-யில் கூறப்பட் முமையாக அறிந்திருக்கிற ப நோயாளி / பெயரிடப்புப்	ண்ட அல்லது மீண் டப்பட்ட நோயாளி றன் என்று நான் 18 றற குள்) எனக்கு 6 ட செயல்பாடு / ந றார். சாத்தியமான வ	ாடும் மீண் பின் பிரத 3 வயதுக்க அரிந்துவி பைமுறை அபாயங்க பிரதிநீதீ.	விளைவுகள் பொது மயக்க மருந்தீ ஈடும் மீண்டும் வெளிப்படுதல் நீநீதி, இந்த வடிவத்தில் கைபெழு த மேற்பட்டவன் என்று இதன்மூல படது. நான் தானாக முன்வந்து எ றயை செய்வதற்கு) அறுவை சிகீச் கள் மற்றும் சிக்கல்கள் மற்றும் சாத இந்த வடிவத்தில் கையெழுத்திடப் படுதல் அளிக்கிறேன் என்று மேலுட	த்தீடப்பட்ட தேதீ, மன ம ம் அறிவிக்கீறேன். எனது ஒப்புதலை வழங் சை செயல்முறையை ந்தீயமான மாற்றுகள் பட்ட தேதீ, மன ரீதீயா	ரீதியாக ஒலி மற்றும் குகிறேன் ச் செய்வதற்கான ம க 18 ஆண்டுகள் நீ	ம் எந்தவொரு டாக்டர் பெயர்.	
				பெயர்		தேதி	நேரம்	
நோயாளி		<u></u>	_				 	
நோயாளிகளின் பிறதீநிதி / பாதுகாவலா் (பொருந்தும் என்றால்)			(நோயாளியுடன் பெயர் ப		o உறவை எழுதவும்)			
நோயாளிகளின் பிரதிநிதி சம்மதத்திற்கான நோயாளி ஒப்பு காரணம்		துல் அளிக்க முடி	பவில்கை	ு ஏனெனில்				
சாட்சி								
<u>-</u>	மொழிபெயர்ப்பாள ர் (பொருந்தினால்)							
,	ியவராக இருந்தால் அ ல்	லது சம்மதத்தை வ	மிர்க மே	2யாவிட்டால் மட்டுமே ஆண்களுக்	கான வலது கை மற்று	ம பெணகளுக்கான	ர இடது கை	
வரும் நடைமுறைச	ன் மற்றும் தி ட்டமிடப்பட்ட	. செயல்பாடு/ நண ள அவர் / அவள் மு	டமுறைக்	ற்றும் சிக்கல்கள், நோக்கம் கொல கு சாத்தியமான மாற்றுகள், நோ மகப் புரிந்து கொண்டார் என்று நா	யாளி / நோயாளி பிர	பார்க்கப்பட்ட பின் ந நீநிதிக்கு விளக்கிய தேதி	டைமுறைக்கு புள்ளார். இந்த நேரம்	

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ANAESTHESIA RECORD



(A Unit of United Alliance Healthcare Pvt Ltd)		,	Every heart beat counts
Patie Mr.SOMASUNDARAM M Typ	e of Surgery : 🗆 [Day Care	ective
Nam: 77/Male/MHI202379692	od Group : 🖣 🤻 🎤	Height: 158 cr	ms Weight : <u> →</u> Kgs
Unit	-Operative Diagno	osis:	Dr. PRAVENN Reg. No. 84510
DOA MANIMANIA PRO	C.	ritical LOI +	Reg. No. 88510
Consum	posed Surgery:	Anaes	thetic Plan
ASA Grade: □ I □ II □ JH □ IV □ V □ E	CARS		ETER C.N
History of Present Illness: COMOR	BIDITY		Present Medication :
Z ANGINA Z HT	☐ SMOK	(ING	
☐ DYSPNOEA ☐ DM ☐ SYNCOPE	ALCO		
I □ MI I □ ASTHN	MA / COPD GERD		
☐ CCF ☐ HYPO	THYROID 🗌 CKD /	ALLERGY	Anti Platelet Stopped on :
Previous Surgery :		ALLEKOT	1.11.23
Physical Evamination :	MC EXAMINATION		'
☐ JAUNDICE ☐ PEDEL OEDEMA		CNS	
CTANOSIS LI CAROTID BRUIT	I(A)	Others	
CLUBBING			
HR: ₹₩ NIBP: \\$9/80	SPO2	2: <u> </u>	TEMP :
INVESTIGATION HB : 12-4 T.BILIRUBIN : 0-5 T3 :	SEROLOGY	ANGIO L	K + 700.
	-ve		
$\begin{array}{cccccccccccccccccccccccccccccccccccc$	Urine:	ECG ST/T	1 - lat-
UREA : 11-50 D. : 01 TSH : 1-05	(,)	0.40	
CREAT: Or 15 T-PROTEINS : HBA1C : 8.9		CXR (b).	
Na+ : 139 S.ALBUMIN :	Others:		
K+ : 4. PTT/INR 10.3 0.3 RBS :		ECHO Ef-	61 11.
APTT 26.2		mild	conc. Lut
AIRWAY CAROTID DOPPLE			
Teeth (2)	^		
Mallampatti class 1			
Mouth Opening		Other Opinions	2,
Neck Movement ()		Other Ophnoria	
TM Distance			
Pre OP Instruction : NPO From: 12	m		
Pre Medication : To Man 40 ~~			
Pre Medication: Topm 40 M Night Before Surgery: Day of Surgery Special Instruction: Tophen 12.5 my		Blood Reservation PCV : (
Day of Surgery Dimorphine 5mg		FFP :	CRYO :
7-1. Managam 12.5my	rm)	Whole Blood:	
Special Instruction :		TTTIOIG DIOUG.	
Remarks:			
Anaesthetist Name with Reg.No. : Dr. P. PR		Signature :	1

	POST OPERATIV	/E PLAN	
Transfer to: SICU	Others, specify:		
Arrival in Recovery / ICL SpO ₂ :% HR: ABP :	Time: 14-00 beats/min Rhythm: 1 nHg CVP: 5 mmHg P	AP:mmHg	breaths/min C.O: L/min score:
		IONOTROPES:	score.
pt. extent	ted an or	N;	
POST OP ORDERS:	- ABB, ACT, (XR - 2 - SLAMIN - vitals manitoring - relieve sos.		
MODIFIED ALDRETE'S SC	ORE (Score against each criteria)		, l
CRITERIA	PARAMETER	Scale	ļ
Activity, able to move, voluntarily or on	4 extremities		4
command	2 extremities	1	Total Score :
	Able to breath deeply and court for	0	· · · · · · · · · · · · · · · · · · ·
Broothin :	Able to breath deeply and cough fr		
Breathing	Dyspnea, shallow or limited breath Apnea	ing 1 0	Patient fit for discharge:
			_ ☐YES □NO]
	Fully awake		-
Consciousnesss	Arousable on calling		1
	unresponsive		1
Circulation	+20% of pre-anaesthesia level +20% to 49% of pre-anaesthesia lev	/el 1	
(Blood Pressure)	+50% of pre-anaesthesia level	0	·
	Maintains SPO, >92% in ambient ai		† l
SPO ₂	Maintains SPO ₂ > 90P% with 9 ₂ .	127	1
	Maintains SPO, <90% with O,	0	j
	Dr. PRAVEE Reg. No: 865:	en H	

Signature

Anaesthetist Name & Reg.No. :



Heally



Mr.SOMASUNDARAM M

OPERATION NOTES

Pre-Operative Diagnosis : ੯ਸ	0, 200 6100d LVF	47/Malc/MHi202379692 05/11/2023/ieH202302190
Post-Operative Diagnosis :	-do-	Dr.RAJESH.V
Operation Procedure OPCA	B x 2	
	mA->LAD RA->OM 2023	Please tick the type of procedure :
Operation Commenced:	Operation 13:45 Completed :	Open ☐ Nature of
Surgeons Dr. And Rayer	Dr. Peaceen PA: Koi	Perfusionist
Anaesthetist Dr. Jeeva		Nurse Ms. Laci /M. Deci
Incision Median stem	otomy	
Cannulation	Arterial	Venous
Oxygenator	Median Sternotamy	I LIMP & LRA hascetted.
Total CPB Time Total ACC Time Total TCA Time Findings and Relevant Details Good Myo Control Cubin	Lyctemii heparinsadii myocardial stabilizes RIMA -> CAD LRA -> OM	on. Hear classifica dene Distal anaetembre dene of Radial artery done onto
LRA-1.70 good scall LRA-1.70 good scall LRA-1.70 good scall LAD-1.80 Thealty tops	Chest closure done	emoitail seured harme
om 1.75m Intransperaedial		

i	RA		LA			Cardiac Output
,	₹٧		LA			CI
	svs			SYS		•
F	PA	MEAN	ВР		MEAN	
	DIAS			DIAS		
F	PACW					
Support:	Isoprin		Adrenaline			
	Dopamine Dobutrex		I A B P Others			
	Dobatiex		Others			
POST-OF	PERATIVE INSTRU	JCTIONS :				
-ABG	ACT Y-104					
	d lose: 200ml.					
	eccon: Nil					
Anhapa	oto d evente . k	deeding,				
		_ _				
			-			<u> </u>
Drains:	Chest - + Plus Mediastinal -	1 - 1				
	Pericardial Others		White !			
Sponge C	ount: Corne	S M Ch(CTVS) nior Consultant to and Vascular	Vajut 1 627	9 <i>u</i> e		
Surgeon :	Dr.					Date: 6/11/23 2 PM

POST-BY PASS HAEMODYNAMICS







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

NAME:	MR. SOMUSUNDARAM	AGE/GEND	ER: 47Years / MALE
UHID NO:	MHI202379692	IP NO:	IPH202302190
DOA:	05/11/2023	DOS:	06/11/2023
SURGEON	I: DR. RAJESH	ANESTHET DR. JEEVAN	=:= : :
ASSISTED	BY: DR. PRAVEEN JEYAKUMAR	PHYSICIAN SAIKUMAR	N ASSOCIATE: MS. I
SCRUB NU	J RSE: MR. SASIKUMAR/MS. DEVIKALA		

DIAGNOSIS:

DOUBLE VESSEL CORONARY ARTERY DISEASE

ACUTE CORONARY SYNDROME - NON ST ELEVATION MI (SEPTEMBER 2023)

NORMAL LEFT VENTRICULAR FUNCTION (EF - 60%)

TYPE II DIABETES MELLITUS

SYSTEMIC HYPERTENSION

SURGERY DONE:

OFF PUMP CORONARY ARTERY BYPASS GRAFTING SURGERY (OPCAB) X 2

LIMA TO LAD

LRA TO MAJOR OM

FINDINGS:

Good myocardial contractions

LIMA - 1.75mm, Good quality, good flow

LRA - 1.75mm, from left hand, Good quality

LAD - 1.5mm, Healthy target

D1 - Small

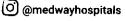
OM – 1.75mm, intra myocardial vessel, Healthy target

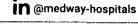
RCA - Dominant, minimal disease

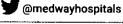
Good distal run off in all the grafts

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<u>PROCEDURE:</u>

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

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

Heart re-positioned and stabilized with myocardial stabilizer for LAD grafting. Arteriotomy was made and 1.5mm 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)

Aorta occluded partially. One 4mm hole was made on the aorta with aortic punch. Proximal anastomosis of artery graft done onto aorta with 6-0 prolene suture. Protamine administered. Hemostasis secured. Routine chest closure done with one mediastinal and one left pleural tubes insitu

SUPPORTS:

He was 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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It comes were properly butter very trease

1	18 Stops	April 19 1 2	10128
11 s. r. q ,	an appeals	and the first of the second se	Physical Strain Commence of the Commence of th
	orta (Left Subclavian Left Internal Mammary Left I
Right Coro			Left Main Coronary Circumflex Obtuse Marginal Diagonal Anterior Descending

Name <u> </u>	the British St.	Date	of Surgery 🔗 🤌	<u> Verris</u> UHL	D. No. 1700 1. 18 19 1
Operation Performed _	13 M/28 13	1. 1. 1. 1. 1.			
	and the second	2:00	(47)		
$\mathcal{F}_{\widetilde{\epsilon}_i}$	Hotory mostre	17.91 1	1 mg 1 1 10 2 1 19	<u> </u>	





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Mr. SOMASUNDARAM M

47/Malc/MHI202379692

05/11/2023/IPH202302190

I'S INFORMATION SHEET

NAME

Dr.RAJESH.V 174 (A) 1840 (A) 1841 (A) 1841

UHID NO AGE / SEX

CONSULTANT	SURGEON	ANAESTHETIST
DR RAJESH	DR RAJESH	DR. PRAVEEN DR. JEEUA.
DIAGNOSIS (In Capital Letters)	1. CAD- RIGHT DON MINTOR OM DISEASE 2. NORMAL LV SY ALDRMAL RV FI 3. MILD CONCENTR TRIVAL MR 4. TRIVAL TR. EF: 61% 5.	uniction.
PRESENT PROCEDURE/ SURGERY	Opund x a yrafis Lima -> Lad Lra -> Om.	
PREVIOUS PROCEDURE/ SURGERY	slp. Hhemokroidecton	ry Donle on 2003.
CONTACT NO. & RELATIONSHIP	1.8939461060 MRS MEEN WIFE (V.C)	12. 8681017980 V.C. MR. SRINIVASAN (COUSIN)

MEDICATION HISTORY

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1	5/11/23	T. ATORUA	Homa	plo	0-0-17	
2	5/11/23	TPAN	Homa	P(O	1-0-1	Continus
3	5/11/23	7 - ANGISPAN TA	2 bmg	plo	1-0-1	
4	, >				.)	
5						
6						
7						
8						
9						
10						
A	NTIPLATLETS	STOPPED AN.	1/11/20	D2 3		
S.No	STARTED ON	CURRENT MEDICATION (After Admission)	i	Route	Frequency	STOPPED ON
1	6/11/23	Byp. SUCRALFATE	10ml	Po	1-1-1	
2	6/11/22	NEB. LEVOLINE	0.63mg	INH	Q6H	
3	7/11/23	T. FRUCENIDE	40mg	Po	1-1-0	
4	7/11/23	T. SPIRANOLACTONE	_	\$-P0	1-1-0	
5	7/11/23	T. CLOPILET - A	75mg	Po	0-1-0	
6	711/23	T. PARACETANIOL	650mg	PO	1-1-1	
7	7/11/23	Sup- CRENAFFIN PL	e 15ml	PO	0-0-1	continue
8	6/11/2	T. DILZEM - CR	90 mg	PO	1-0-1	
9	7/11/23.	T. BEPLEY FORTE		Po	1-0-0	
10	7 11 23	T-ROSUVASTATINI	40mg	Po	0-0-1	
1]. 12.	7/11/23	T. METAPROLOL T. PREGARYN	25 mg 75mg	P 0 P0	1-0-1	

ANY RELEVANT INFORMATION:

Admission / OT Receival Date and Time: 6(11/2 3 At (4.00) From: 01 To: S(U	Condition of the Patients 1. Stable / Unstable 3. Conscious / Semice 4. Febrile / A febrile	ent : onscious / Unconscious	2. Oriented / Disoriented 5. Intubated / Extubated
Transfer Out		4	
Date and Time: 08/11/03 From: 8DICO To: GW	Condition of the Pation 1. Stable / Unstable 3. Conserous / Semicon 4. Febrile / A febrile	onscious / Unconscious	2. Oriented / Disoriented5. Intubated / Extubated
Transfer In	Condition of the Pation	ent:	
Date and Time :		onscious / Unconscious	2. Oriented / Disoriented
From: To:	4. Febrile / A febrile	Ī	5. Intubated / Extubated
1) Known Case of Diabetic Mellitus 2) Known Case of	Year 5 YEARS	Months	Days
3) Known Case of Bronchial Asthma/COPD	4 YEARS		
4) Known Case Of Others	-		
Denture	☐ Yes ☐ Permanent Fixatio ☐ Temporary Fixatio	No on: Present / Absent	
Allergic Reaction : Drugs/Food	☐ Yes If you means mention a	No about Drug / Food Name	·:
Pressure Ulcer Present	Yes If you means mention a	No No about Grade : 1/2/3/4	4 & Site:

ANY RELEVANT INFORMATION:

					Sign With Date
Peripheral Cannulation	1. Site: RUHT CUBITAL, 2. Site:	1. Inserted Da 6 11 2 3 A 2. Inserted Da	T 9.40	1. Removed on: [0]u]33 2. Removed on:	Nue 024 10/1/83
	3. Site:	3. Inserted Da	te and Time	3. Removed on :	
Neek Line: YJL/EJL	Site: RIGHT	Inserted Date		Removed on OB(11) 23 @ 11.30	\$
Arterial Line : Right/Left	Site: RADIAL	Inserted Date		Removed on Thile 3 Allo:30	Man
Sheath Arterial / Venous:	Site:	Inserted Date and Time		Removed on	
Pressure Bandage	Site:	Inserted Date	and Time	Removed on	
Drain Site	1. Mediastinal: Inserted Date and Time b 11 23 AT 13 40 2. Pleural Right / Lett: Inserted Date and Time Removed on Removed on				Los
Urinary Catheterization	Inserted Date and Tim		Removed or	1 3 (A) 4:45	127365
Nasal / Oral Gastric Tube			Removed or		
Intubation Date and Time				n Date And Time	
Other Information	PATIGNT SHOULDER PAIN SIDED CHEST P CALL DONLE SCREENLING ECG DONLE	IB), Jai Haid onl Honla	nd pain 1819/23 25/09/20	AND LIFT	200





Mr.SOMASUNDARAM M

47/Malc/MHI202379692 05/11/2023/;PH202302190

Dr.RAJESH,V





PATIENT'S INFORMATION SHEET

NAME Soma Sundarom		AGE/SEX 47/M		UHID NO 20237 9692	
CONSULTANT		SURGEON		ANAESTHETIST	
DR. RAJESH	DA	. Rajuh V	D	Dr. PRAVEEN	
DIAGNOSIS (In Capital Letters)	1.	CORONARY ART	ER	Y DISEASE	
	2. C	AD - RIGHT DOM CRITICAL L		NT - MAJOR OM	
	3.	BODERLINE	LA	D	
	4.				
	5.				
	6.				
	7.		-		
	8.				
PRESENT PROCEDURE/ SURGERY	ł	RAFTING	В	Y E PASS	
PREVIOUS PROCEDURE/ SURGERY	H	10 Haemoerchoid	ect	omy zo years	
CONTACT NO. & RELATIONSHIP	1	s. MEENA (WIFE) 161060	2.		

MEDICATION HISTORY

S.No	STARTED ON	PAST MEDICATION (On Admission)	Dose	Route	Frequency	STOPPED ON
1		Inj Regular Insuli	40IU/ml	SIC	6-0-6 units	5/11/23
2		Juj. NPH	40 IU/m	SIC	6-6-6 units	5/11/23
3		T. WINTRO	2.6 mg	PO	1-0-1	5/11/23
4		T. PAN	40 mg	PO	1-0-1	5/11/23
5		T. METFORMIN	soony	ρο	1-0-1	5/11/23
6		T. GLIMEPIRIDE	ing	PO	1-0-1	5/11/23
7		T. CLOPIDOUS REL	75 mg	PO	0-1-0	31/10/23
8		1. ECOSPIRIN	15mg	PO	0-1-0	31/10/23
9		T. ATORVAS	40mg	PO	0-0-1	4/11/23
10		C. ZIM Vitamin (g	o I cap	PO	1-0-0	5/11/23

S.No	STARTED ON	CURRENT MEDICATION (After Admission)	Dose	Route	Frequency	STOPPED ON
1		T. ATORVAS	40mg	PO	0-0-17	
2		7.PAN	40mg	PO	1-0-1	Continue
3		T. ANGISPAN TR	2.6mg	PO	1-0-1	
4)	
5						
6						
7						
8						
9						
10						

ANY RELEVANT INFORMATION:

Admission / OT Receival Date and Time : From : To :	Condition of the Patie 1. Stable / Unstable 3. Conscious / Semico 4. Febrile / A febrile	onscious / Unconscious	2. Oriented / Disoriented5. Intubated / Extubated	
Transfer Out Date and Time: 5 11 23 6 From: 7 to: 0 T	Condition of the Patie 1 Stable Unstable 3 Conscious / Semico 4. Febrile / A febrile	onscious / Unconscious	2. Oriented / Disoriented s 5. Intubated / Extubated	
Transfer In Date and Time: From: To:	Condition of the Patie 1. Stable / Unstable 3. Conscious / Semice 4. Febrile / A febrile	onscious / Unconscious	2. Oriented / Disoriented 5. Intubated / Extubated	
1) Known Case of Diabetic Mellitus 2) Known Case of Hypertension 3) Known Case of Bronchial Asthma/COPD	Year 5 YEARS A YEARS	Months	Days	
4) Known Case Of Others				
Denture	☐ Yes ☐ No ☐ Permanent Fixation ☐ Temporary Fixation : Present / Absent			
Allergic Reaction : Drugs/Food	If you means mention about Drug / Food Name:			
Pressure Ulcer Present	Yes If you means mention a	No about Grade : 1/2/3/4	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: Inserted Date and Time		Removed on	<u> </u>	
	2. Pleural Right / Lei	ft: Inserted Da	te and Time	Removed on	
Urinary Catheterization	Inserted Date and Time		Removed or	1	
Nasal / Oral Gastric Tube	Inserted Date and Time		Removed or	1	
Intubation Date and Time	Extubation Date And Time		Reintubatio	n Date And Time	
Other Information	100 p	ow (Bull bank (servatu SINI	on clone. Vennila	7





SAFE PROCEDURE CHECKLIST Adapted from WHO Safe Surgery Checklist

MHI/OT/2022/086 Medwau Heart Institute

Every heart beat counts

Mr.SOMASUNDARAM M

47/Male/MHI202379692

Name of the Procedure : OPCAR (CLOSED HEART) _____ Date & Time : 06/11/23@ 05/11/2023/IPH202302190 Dr.RAJESH V Does the Procedure involve Procedural Sedation: Wes \ No \ J, General Anewsthesia. SIGN IN ' 9: 6 D TIME OUT: 10:40 SIGN OUT 13:55 Before Induction Procedural Sedation After procedural Sedation and before procedure When Doctor indicates that the Procedure is completed (Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor (Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure) performing the Procedure Patient Confirmation All team members introduce themselves by Name and Role To be done for each procedure in case of multiple proceduresYes Yes **⊥**Yes Identity by two identifiers Name of the Procedure done written down Identity by two identifiers Name and site of all specimens / investigations Yes AA Procedure ∏ Yes Procedures Yes confirms labeling and sent to lab Side □Rt □Lt □NA □Rt □Lt □NA Side CHEST, It hand CHEST LE HOME Expected Blood loss 300-400 ml **₽**Yes ☐ Yes ITHOne **□** Yes Position ! SUPINE Any recovery concerns: Consent If Yes. Pls. specify: THYes TYes TNOT KNOW Consent Known Allergy If yes, plaese specify Required equipment and implants available □Yes □NA PYes TNA Essential Imaging displayed Difficult airway / aspiration risk No ☐ Yes, equipmen and assistance available PYes INA / dentures Antibiotic prophylaxis within last 60 minutes Name of the Antibiotic given In. Cesturoxi me 1-Any Equipment / instrument problem that needs to be 59m@4.40 Possibility of hypothermia ☐ No ☐ Yes, warmer in place ☐ Yes Takone addressed: Venous Thromboembolism Prophylaxis Provided ☑Yes □ NA If Yes, Pls, specify: All concerned anesthesia equipment and medication check complete ₩ es Anticipated duration briefed D8po2 DMIBP Others pls. specify ☐Yes ☐ NA Anticipated blood loss briefed TY'es □ NA √ZYYes □ No Pre OP medication taken Adequate fluids and blood available ΓλΥ es Team briefed on any critical or unexpected steps Corrective action: Required equipment for ∏X/es □ NA For procedural sedation cases Nh ☐ Yes ☐ None Any patient specific concerns procedure available Intra procedure glycemic control THYes | NA ☐ Yes ☐ Mone Any concerns about sterility Nurse: RIN SUBATHA Technician: SATHYA Others Please Specify: I/c CHUSTN Anaesthetist / Doctor giving Doctor performing the Procedure DE RATESH. Procedural Sedation: Dr. JEWA 036 Dr. Papucito Date: 66/11 Date: Date: Time: 13:55 Time: 66/11/23@>13:55

Time:





MHI/IP/2022/067



CONSENT FOR BLOOD / BLOOD COMPONENTS

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

Red Cells for bleeding or low hemoglobin

Platelets for bleeding or low counts

Plasma for restoring blood volume or providing clotting factors

Cryoprecipitate for special clotting factors

The Doctor has explained the benefirs 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.
- 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.
- 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.

5 N.	Patients name MR . 50 MA SUNDARAM
Witness 5. D. D. 1. L. Doctor Doctor	
Time	Patient signature MR5 MEENA Guardians name MR5 MEENA Guardians signature
Date	Relationship to patient WIFE

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

Time: 3 00	Date: 5/11/23	Doctors Signature: Dr. P. PRAVEEN Reg. No: 86510
,900		Reg. No: 86510





தேதி:



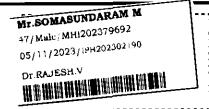
ஒப்புதல் : கிரத்தம் / கிரத்தத்தீன் பாகங்களை செலுத்துதல்

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

	The second of th
சிவப்பு அணுக்கள்	இரத்தப்போக்கு அல்லது குறைந்த ஹீமோகுளோபினுக்கு
தட்ட ணுக்க ள்	இரத்தப்போக்கு அல்லது குறைந்த எண் ணிக்கைக் கு
<mark>கருதிந</mark> ீர்	இரத்த கன அளவை மீட்டமைப்பதற்கு அல்லது உறைவு அம்சங்களை வழங்குவதற்கு
கீரையோபிரைஸிபிடேட்	சிறப்பு உறைவு அம்சங்களுக்காக
எனக்கு /நோயாளிகளுக்கு இரத்தம் வ	சலுத்தப்படுவதன் மூலம் எதிர்பார்க்கப்படும் நன்மைகள் மட்டுமின்றி இடர்களையும் மருத்துவர் விளக்கியுள்ளார்
1. இரத்தம் செலுத்துவதீல் கீடைக்கி	ன்ற விருப்பத்தேர்வு பற்றி எனக்கு தகவலளிக்கப்பட்டுள்ளது. இதில் தன்னார்வ தானமளிப்பவர்கள் வழங்கியுள்ள வங்கியிலுள்ள
இரத்தம் (அமோஜெனிக்) அல்லது சுடி	யமாக தானமளித்தல் (ஆட்டோனோகஸ்) ஆகியவை அடங்கும். ஓர் அவசரநிலையில், வங்கி இரத்தம்தான் பயன்படுத்தப்பட
வேண்டியிருக்கும். நேரம் கீடைக்கும்	பட்சத்தில் சுய தானமளிப்பதற்கு வாய்ப்புள்ளது.
2. தேசிய விதீமுறைகளுக்கேற்ப	ப கவனத்துடன் <mark>முன்சோதனை</mark> செய்யப்பட்டிருந்தா <mark>லும், உயிருக்கு ஆபத்தை விளைவிக்கக்கூடிய தொற்றுக்கான எய்ட்ள்</mark>
ஹெபடைடிஸ் மற்றும் இதர வைரஸ்க	கள் அல்லது இதுவரை அறியப்படாத நோய்கள் ஏற்பட்டுள்ள அரிதான நிகழ்வுகளும் உள்ளன. எல்லாவிதமான இடர்களையுட
நீக்குவது என்பது நடைமுறைக்கு 🙈	்யலாத ஒன்றாகும் என்பதையும் நான் புரிந்து கொள்கீறேன். கணிக்க முடியாத எதிர்விளைவுகளும் தோன்றலாம். இவை
காய்ச்சல், பொரிப்பு, மூச்சுத்திணறல், எ	அதீர்ச்ச <mark>ி மற்றும் அரிதான நிகழ்வுகளில் இ</mark> றப்பு ஆ <mark>கியவற்றை உள்ளடக்கி. அந்த வரம்புக்குட்படாதவையாகவும் கூட இருக்க</mark> லாப்
என்பதையும் நான் புரிந்து கொண்டே	इंग.
 இரத்தம் செலுத்துவதன் கு 	ழலம் எதிர்பார்க்கப்படும் நன்மைகள், அதிர்ச்சி, மூளை மற்றும் இதர உறுப்புகளுக்கு ஏற்படும் சேதம் குறைக்கப்படுதல்
குணமடைதலை துரிதப்படுத்துதல்	மற்றும் இரத்தம் <mark>இழக்கப்படுவதைக் குறைத்தல் ஆகியவற்றை உள்ளடக்கியிருக்கலாம் என்றாலும், எதீர்பார்க்கப்படும்</mark>
நன்மைகளுக்கு உத்தரவாதம் ஏதும் ச	9ளிக்கப்படவில்லை என்பதையும் நான் புரிந்து கொள்கிறேன்.
 இரத்தம் செலுத்துதல், மாற்று சில் 	கீச்சை முறைகள். சிகீச்சை எடுக்காமல் இருப்பதி <mark>லுள்ள அபா</mark> யங்கள், பயன்படுத்தவிருக்கும் செயல்முறைகள், மற்றும் இதிலுள்ள
இடர்கள் மற்றும் அபாயங்கள் ஆகீய	வை பற்றிய கேள்விகள் கேட்பதற்கு எனக்கு வாய்ப்பிருந்தது. மேலும் தகவலறிந்த நிலையில் முடிவெடுப்பதற்கு ஏற்ப எனக்கு
போதிய விவரங்கள் தெரிந்திருந்தன எ	ன்று நான் நம்புகிறேன்.
5. முறையான மருத்துவ பர	ாமரிப்பின் பொருட்டு, இரத்தம் மற்றும் / அல்லது அதன் பாகங்கள் செலுத்தப்படுவதற்கு நான் ஒப்புக்கொள்வதுடன், எனத
கையொப்பத்தீன் மூலம் எனக்கு அல்	லது நோயாளிகளுக்கு இரத்தப் பொருட்கள் செலுத்தப்படுத்துவதற்கு என் ஒப்புதலை அளிக்கிறேன். இதே நோய் தொடர்பாக
இ ரத்தப் பொருட்கள் செலுத்தப்படுவ	பதற்கான எதிர்காலத் தேவைக்கு வாய்ப்பு <mark>ள்ளது மற்றும் அது தொடர் அடிப்படையில் இ</mark> ருக்கலாம் என்று எனக்கு <u>ச</u> ்
தெரிவிக்கப்பட்டிருக்குமானால். இந்த	த மருத்துவமனை சேர்ப்பின் குறிப்பிட்ட காலத்தில் முடிவடையும் வகையில் அல்லது இந்நோயின் முமுமையான
காலகட்டத்திற்கும் தேவையான கூடுத	தல் இ ரத்தப் பொருட்கள் செலுத்தப்படுவதற்குரிய ஒப்புதலையும் இ த்தகவறைிந்த ஒப்புதல் மூலம் வழங்குவதற்கு நான் ஒப்புக்
கொள்கீறேன்.	
	நோயாளியின் பெயர்
சாட்சி	நோயாளியின் கையொப்பம்
மருத்துவர்	அல்லது பாதுகாவலரின் கையொப்பம்
நேரம்	பாதுகாவலரின் கையொப்பம்
தேதி	
உயிருக்கு ஆபத்தான / அவசரக்கால	o மருத்துவ நிலை காரணமாகத் தகவலறிந்த ஒப்புதல் பெறப்படவில்லை. தகவலறிந்த ஒப்புதலாகக் கருதப்படக்கூடிய அளவிற்கு
நான் போதிய அளவு தகவலை நே	நாயாளிக்கு வ <mark>ழங்கீனிட்டேன். மேலு</mark> ம் ஓர் உயிருக்கு ஆபத்தான / அவசரக்கால மருத்துவ நிலையை மாற்றுவதற்கு
மேம்படுத்துவதற்கு. நேர்மாறாக ஆக	க்குவதற்கான போதிய அளவில் இரத்தப் பொருட்களை வழங்குவதற்கான உத்தரவை வழங்கும் நடவடிக்கையை நான்
மேற்கொண்டுள்ளேன்.	
நேரம் :	
நோயாளியீன் பெயர் :	மருத்துவரின் கையொப்பம்









CONSENT FORM - PHYSIOTHERAPY

)	the Patient or peresentative of patient have (please tick the correct option above and below): Read I/We have been explained the current clinical condition of me/my patient Been explained this consent form in
	DULMONARY Paha Crutation (full name of operation / procedure given below in this consent form)
	Brief description of the Operation/Procedure: DE's, Chest Pencussian. Afrom Ens. Spirometry En's, Mobilization
)	I understand the intended benefits of undergoing the procedure. The intended benefits from this procedure are: TO Emprove ADI, TO Emprove FRom, TO Clean out Lung Scretion, To Improve Chart Expansion I understand that all procedures carry certain risks. The potential risks and complications from this procedure:
	Pain
	I have been explained the implications of not undergoing this procedure and the alternative methods of treatment like:
	Nij
	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.

		ive, do further hereby declare that I am above to consent without any fear, threat or false miscond		s on the
	Signature / Thumb Impression*	Name	Date	Time
Patient				
Surrogate/Guardian (if applicable #)	* N. Sunger	Mr.Snikivosan(Write name and relationship with patient)	6/11/23	18100
Reason for surrogate consent	Patient is unable to give consent	because:		•
Witness	, John	* ARNO	6/4/23	(8'00
Interpreter (if applicable)				

Signature of Patient / Patient's Relative (only if Patient is unable to sign):

intended benefits and possible alternatives

For the above mentioned operation(s) / procedure(s) that I have been made aware of, I give my consent voluntarily to

	Signature	Name	Reg. No.	Date	Time
Consent obtained by	J.m.	J.vyayaexcauan	2102	6/11/12-3	18100
Procedure performed by	7.5	Jungapacanan	2102	6/11/23	(t t\00,

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.



MI.SOMASUNDARAM M

47/Male/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V





IN-PATIENT INITIAL ASSESSMENT FORM - PHYSIOTHERAPY

Chief Complaints: PT 0 (0 P I roulder pain, Our pain x	Jan pain of D Sides			
Out post is	2 moth book			
Occupation: Heavy Activity Moderate Activity	Light Activity			
Pasit Medical / Surgical History: Kiclo DM X5 474 Kiclo HTN X4 474				
Stp Haemorrhodict	ony ×2003			
On Observation* Built: ☐ Thin ☑ Fair ☐ Well Built ☐ Obese Postural Deviation: Deformity: ☐ Yes ☑ No Swelling: ☐ Yes ☑ No Gait Deviation:				
On Palpation: Tenderness: Yes No Warmth: Yes No Muscle spasm: Yes No Oedema: Yes No Crepitus: Yes No Tone; Normal Abnormal				
FALL RISK SCREENING NIL				
Fall Risk Screening for Adults: Age more than 65 years	History of fall in last 3 months			
☐ Walks with assistance ☐ Any neurological problem				
In case of 2 or more criteria is met, initiate detailed fall assessment and fall prevention protocol.				
Fall Risk Screening for Pediatrics: H/O fall in last 3 months Neurological problem (vertigo, some state of 2 or more criteria is met, initiate detailed fall assessments)				
Respiratory Status:	Brain Injury (if applicable): NA			
☐ Room Air ☐ O₂ Support ☐ Ventilatory Support ☐ BIPAP	☐ Traumatic ☐ Non Traumatic			
Trachard Mark T Nearl Branca T Track Mark				
☐ Tracheal Mask ☐ Nasal Prongs ☐ Face Mask	☐ Mild ☐ Moderate ☐ Severe			
Intubated: Yes No	☐ Mild ☐ Moderate ☐ Severe ☐ Conscious ☐ Unconscious			

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: NL				
☐ 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): Ni				
Dyspnoea Grading Scale:				
Abnormal Breathing Sounds: Wheezing Stridor Crackles Pleural Rub Pneumothorax Click Stertor				
Abnormal Breathing Pattern:				
Pain Assessment: Pain: ☑ Yes ☐ No				
Pain Score: 6 0				
Tick whichever is applied: □ Numerical Rating Pain Scale □ Visual Analog Scale □ Wong-Baker Faces				
Pain Scale Critical Care Pain Observation Tool FLACC				
Pain Scale Critical Care Pain Observation Tool FLACC Location: Onld Shouldly, Duration: Smooth both Frequency: — Character: — Town				
Pain Scale Critical Care Pain Observation Tool FLACC Location: Onld Should! Duration: Smooth Burning Aching Radiating Numbness				
Pain Scale Critical Care Pain Observation Tool FLACC Location: Should Should				
Pain Scale Critical Care Pain Observation Tool FLACC Location: Should Should				
Pain Scale Critical Care Pain Observation Tool FLACC Location: Should Should				
Pain Scale Critical Care Pain Observation Tool FLACC Location: Should Should				
Pain Scale Critical Care Pain Observation Tool FLACC Location: Should Should				
Pain Scale Critical Care Pain Observation Tool FLACC Location: Should Should				

Examination	(Please tick and mention at	onormal findings only):			
☐ Range of M	Notion:				
	Normal				
☐ Muscle Str	ength:				
	Normal				
☐ Reflexes:					
	Normal				
Plantar Respo	onse: Diminished Bris	sk □Clonus			
Biceps: Dir	minished □Brisk □Clonu	S			
Triceps: 🗹 Di	minished □Brisk □Clonu	ıs			
Supinators:	Doiminished □ Brisk □ C	lonus			
Knee: □∕Dimi	inished □Brisk □Clonus				
l /	inished □Brisk □Clonus				
Investigation	& Findings: CAD— Owlfood I	ex - majorom + 1 Shr	Borderlâng LAD V/ NHV.	Ty-II DI	M/
Physiotherap	y Management Plan: Services Clu	breathing exercises analy exercises at percuestor to Alkons to B/L OL Mobilization	ve, Bli duet w. LLL	all	
	Signature	Name	Emp. No.	Date	Time
Physiotherapist	G. & Alkay	AKASH. G.E	025%	6/11/23	17:00

	RE-ASSESSMENT FORM
Date & Time Stul 23 Li:00	Fall Risk Score: 3/10 Pain Score: Sunghal Site pain - Dies enouraged - John possession to the dust wall - Might Latter - To Imperent Joint Pon - To Imperent Lung capacity Stundtes - To Imperent Breathing
	Post Intervention Pain Score:
	For openator Candrar Polinarary Delials totto
Dhysiatharenict	Signature Name Emp. No.
Physiotherapist	Signal Rugge Cit Cash





Medway Hospitals®

The way to better health
PHYSIOTHERAPY TREATMENT CHART

Mr.SOMASUNDARAM M

47/Male/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V

117 M 1181 M

DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
6/11/23	14:0c	S/B rijayaraghanan - PT ortable oxtribation - Deer emouraged - Sprometry our ourowagld - This books trp: 600% - Apon to Ble U fle	G. F. Cheol HH 10256
2/11/23	9:00	S/B AKASH - DBC evenuraged - Sprometay ou eucowaged - Sprometay ou eucowaged - Ins: book Exp. book - AROW ex to Ble ULGLE	GENROY MH10251
=: ₁₁ 23	£100	S/B AKASH -DBey encouraged - Sprometry six encouraged - Sprometry six encouraged - The book Exp. book - Alton où to B/L VILLUL - Chest permuera to B/L Chest wall	G. E. Akad MH10256





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Dr.RAJESH.V

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	<u>,</u>	т		
	DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
	1 [11 23	9:00	S/B Ramarathan.p	
			-DBE'S encounaged -Chart percussion to BL Chest wall -AROM Er's to BL UL 2 LL -Spirometry Gr's encouraged Ens: 600 L Grp: 600cm	mH1 0260
	7/11/23	17:00	S/B vijayan anghanan - DBer encouraged - Spironetry en encouraged In: boocc txp: boocc	Httt0256
	711/23	d1:00	- Char paramera to Ble Chart wall - AROM to Ble UL fle - pt char Mobilized. Sle AKABH - Dear encouraged - Spisonetry ext encouraged Turi boore texpiboore - Chart paramera to Ble Chart wall AROM to Ble UL fle	G1.E Shall MH10256





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Mr.SOMASUNDARAM M

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PHYSIOTHERAPY '		OLIADE
DHAZILIBEDVDA		CHADI
FILLSICHTERAFI	INLAHULINI	CHARL

		PHYSIOTHERAPY TREATMENT CHART	-
DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
8/11/23	6:00	S/B AKABH	G.B. Okas MH10256
		- DBer encouraged	N. H10256
		- DBer encouraged - Spranetry on Oncouraged Ins: books Exp: books	M,
		Ins: booce Exp: booce	
1		al of powerries 10 Bic	
		dust wall -prom to ble vette	
		-AROM DE BIL DEACE	
		- pt draw Mobilized	
8/11/23	9.30	S/B Damanothan P	
		-DBE's encouraged	
		- Chest Percusion to Bli Chart wale	4
		-AROM Ext to BL UL ELL	Λφ.
		"Spirometry A's Encouraged This: book Exp: 600kc	m H10260
		Ins: book Exp: 600k	
		- Pt Mobilised	
3/11/23	[J] 00	S/B ALAS Vijayaraghan	În.
,		- DBO Eucouraged	G'E STON
		- Sprometry Grannaged	NH0256
		A somewhood true	
		diest vall	
		- PT Mobi lited	





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Mr.SOMASUNDARAM M

47/Malc/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V

DATE TIME PHYSIOTHERAPY TREATMENT REMARKS So Ramanothan - Deer encouraged - Sprinnly encouraged - Apom to Bit vielle Sprinnly encouraged - Promity encouraged - Sprinnly encoura			PHYSIOTHERAPY TREATMENT CHART	112 All Child had the base (Section 1991) and section 1991
- Des Euromogod - Sprinnly Oranged - Chart parameter to Ble - Chart parameter to Ble - Apom to Ble Vielle - Des oucouroald - Sprinnty Oranged - Sprinnty Oranged - Sprinnty Oranged - Sprinnty Oranged - Chart parameter to Ble - Chart parameter to Ble - Chart wall - Akon to Ble velle	DATE	TIME	PHYSIOTHERAPY TREATMENT	REMARKS
- Sprendly amount to Ble - drust parameter to Ble - Dec accounted - Sprendly amounted - Area percular to Ble - Area to Ble vedle	9/11/23	16/00		G1.5 3400
- De Succernaged - De Succernaged - Sprometry Encuraged - Sprometry Exp. Good - Sur porcular forste - Sur porcular forste - Arom for Ble velle			- Sprometry arconnerger - dent percursión to Ble Quest oval - Depon to Ble VedLC	
- Ared permeller to ble Check wall - Arom to Ble vedle	0/11/23	14100	S/B AKASIA	+ Akao
- AROM to BL VELLE			- Der succernaged - Sprometry oneuroged - Tex: 600 cc txp: 6000	M+110256
1			- AROM to BL VELL	·
	į			





MI.SOMASUNDARAM M

47/Malc/MHI202379692 05/11/2023/:PH202302:90

Dr.RAJESH.V

URINE ROUTINE ANALYSIS

MICROBIOLOGY SHEET

URINE ROUTINE ANAL	1313 1111111111111111111111111111111111	- 101 Illi Late and ann canadasa an ann ann
DATE	29/10/22	
COLOUR		
REACTION	6.5	
SPECIFIC GRAVITY	1.010	
APPEARANCE	CLEARE	
ALBUMIN	-	
SUGAR	NJ	
ACETONE	Neachie	
BILE SALT	Degativ	
BILE PIGMENT	Negative	
UROBILINOGEN	Noomal	
PUS CELLS		
EPITHELIAL CELLS		
RBC	(I)	
CASTS	N/O	
CRYSTALS	(1)	
OTHERS	Ni)	
L		

MICROBIOLOGY-CULTURE REPORTS

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





Mr.SOMASUNDARAM M

47/Male/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V

DIABETIC CHART

In Replay malin 6-0-6 unin, in NOH- 6-6-0 union.

HbA,c. 8:7.7. ACTUAL WEIGHT PREVIOUS DIABETIC MEDICATIONS DIABETIC DRUG DATE TIME **BLOOD SUGAR** Sign. **ENDORSED BY** = 163244 رے NDO

INSTRUCTIONS FOR INSULIN INFUSIONS

BLOOD SUGAR

*	Mix 40u short acting Insulin in 40 ml. of	mg / dl	INSULIN INFUSION
*	normal Saline (1u - 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 renewing, agentimis	251-300	Adjust Infusion rate to 6u / hr.
*	Target Blood Sugar 150-200 mgs.	301-350	Adjust Infusion rate to 8u / hr.
*	To monitor K+ separately.	351-400	Adjust Infusion rate to 10u / hr.
	Urine Acetone	>400	Adjust Infusion rate to 20u / hr.







Every heart beat counts

Mr.SOMASUNDARAM M

47/Male/MHi202379692 05/11/2023/PH202302190

Dr.RAJESH.V

: DO NO LICENSO DE LA COMPONIO DE L

ΠΙΔ	BFTIC	: CH	ΔRT

ACTUAL WE	EIGHT	[0 60]. HbA,c.	8.9 % IN	J. Kegular Inlsi	DLIN 6-0-6 UNLIS
PREVIOUS I	DIABETIC	MEDICATIONS I METERORMINI	500mg (-0-1(pg)	Hqlv Ch	6-0-6 UNIS.
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
6/u/23.	15:00	162 mg/dl	-	May	BR. PRAYEGAL.
	19:00	165 mgld)	_	Marious	DR. Sylvester
	23.46	148 eg (dl)		Charle Conta	DP. SYLVESTER
1/11/23	6.30	180 mg/dl	T-GLIMIPRIDE 2mg/ques	Margara	DR. SYLVESTER
	1300	154 mg/d)	_	19 Vanja	DR PRAVEEN.
	19.00	138 mg/dl	T. GHINDPEIDE 200 CONTROL 201	0 2005	DR. PRAVEEN
oly ba	7.00	120 mg/dL	T. WHIMPE DE 2nd @8.3 T. METFORMIN SOONGGY	10740	DR. PRIVERY
	2:30	100 mg [d]		00/2/00	Dh 1103)7
	18.30.	119 mg/dl	a worthamil cong.	DC SACH	selly.
व ॥व3	6-30	200 mgldl	Inj Regular Trylor 6-0-6 Inj NPH 6-0-6	In Julios	DA PRAVEEN
	D'So	120 mglas	wi Ny w - Kan	Dan Je	Ph150327.
	18-30	180 mg/dli	T-acineprise and	FOROT O	Dr. praces
		<u>INSTRUCTIONS FO</u>	<u>OR INSULIN INFUSI</u>	ONS P	η

* Mix 40u short acting Insulin in 40 ml. of normal Saline (IU - 1 ml.) * Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.). Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.). | 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.

BLOOD SUGAR

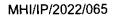
* Monitor Blood Glucose hourly (every 2nd hourly when stable) and adjust Insulin rate according to the following Algorithm.

Target Blood Sugar 150-200 mgs.

To monitor K+ separately.

Urine Acetone

	Then restart infusion with rate 1 u / hour.
150-200	Adjust Infusion rate to 2u / hr.
201-250	Adjust Infusion rate to 4u / hr.
251-300	Adjust Infusion rate to 6u / hr.
301-350	Adjust Infusion rate to 8u / hr.
351-400	Adjust Infusion rate to 10u / hr.
>400	Adjust Infusion rate to 20u / hr.







DIABETIC CHART

Medway

Mr.SOMASUNDARAM M

47/Malc/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V

ACTUAL W	EIGHT	FOK9 HbA,c	8,9	THE RECUER	Emplin 6-06 only
PREVIOUS	DIABETIC	Tonedformin & MEDICATIONS	soong 1-0-1 (AF)	Im 124	stime do so assent
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
10/11/23	6.30	180 mg/dl	In ilamologia st	AN 8 00 m	Dr. Pagyanan
	12 .30	180 mg ld1	_	Bur	Ph150327
		· · · · · · · · · · · · · · · · · · ·			
		\			
_					
			7		

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.
	ŭ ŭ	251-300	Adjust Infusion rate to 6u / hr.
*	Target Blood Sugar 150-200 mgs.	301-350	Adjust Infusion rate to 8u / hr.
*	To monitor K+ separately.	351-400	Adjust Infusion rate to 10u / hr.
	Urine Acetone	>400	Adjust Infusion rate to 20u / hr.







Every heart beat counts

Mr.SOMASUNDARAM M

47/Male/MHI202379692 05/11/2023/iPH202302i90

Dr.RAJESH.V



BLOOD GROUP

11	1,	
D		Position
	_	0 —

INVESTIGATION SHEET

Date	22/10/13					
HAEMATOLOGY	,		-			
Hb	12.4		_	<u></u>		
P.C.V	38.2					
Platelets	325000					
TLC	7270					
Polymorphs	57.0					
Lymphocytes	25.3		<u> </u>			
Eosinophils	4.4					
Mono / Basophils	,					
E.S.R						
BIO-CHEMISTRY						
Urea	11.60		<u> </u>			
Creatinine	0.65-					
Sodium	139					
Potassium	4-19					
Bicarbonate						
Chloride						
Magnesium					_	
Calcium						
Phosphorus			<u></u>			
LFT						
T.Bilirubin	0-315					
D.Bilirubin	0.137					
I.Bilirubin						
S.G.O.T	0 177					
S.G.P.T	110					
ALP	110					
GGT						
Total Protien	<u> </u>					
S.Albumin_			ļ			
CARDIAC ENZYMES		!				
Troponin I						
CKNAC - CPK						
CK - M.B. MASS	<u>-</u>					
LDH						
Ntpro bnp						

	1 . 1		 -	1		
Date	10.7/0,9					·
COAGULATION	,					
PT / INR	10.7/0.9					
Fibrinogen		_				
D-Dimer appr	28.8/26.2					
LIPID PROFILE						
Total Cholesterol						
Triglyceride						
H.D.L						
L.D.L						
VLDV						_
THYROID FUNCTION						
T.S.H	1.055		j			
T.3	VIGHE					
T.4	1.0)					
SEROLORY						
HIV ()						
HBsAg /	Non Ros obis					
V.D.R.L						
COVID 19						
RT- PCR						
IgM						
lg						
HBA1C	8.9					
FBS/PPBS	/		-			
					l .	
RBS						
RBS						
RBS S.AMYLASE						
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Every heart beat counts

Mr.SOMASUNDARAM M

47/Male/MHi202379692 05/11/2023/IPH202302190

Dr.RAJESH.V



BLOOD GROUP

A POSITIVE

INVESTIGATION SHEET

Date	27 10 23	7/11/03	08/11/03	9/11/23		
HAEMATOLOGY		77.7	,	''		
Hb	12.4	13.0	11-4.	10.6		
P.C.V	38.2					
Platelets	325000					
TLC	7270					
Polymorphs	57-0					
Lymphocytes	25.3				•	
Eosinophils	4.9					
Mono / Basophils	١.					
E.S.R						
BIO-CHEMISTRY		2.4				
Urea	11.60	થે 6	32	13729		
Creatinine	0.65	0.48	0.55	0.71		
Sodium	139	•	135	0.71		
Potassium	139 4.19		4.21	4.48		
Bicarbonate						
Chloride						
Magnesium						
Calcium						
Phosphorus						
LFT						
T.Bilirubin	0.315					
D.Bilirubin	0.137					
I.Bilirubin						
S.G.O.T	0.177					
S.G.P.T	19					
ALP	110					
GGT	,					
Total Protien						
S.Albumin						
CARDIAC ENZYMES			•			
Troponin I						
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp						

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D Dimer ADT	388 26 8					
LIPID PROFILE	<u> </u>					
Total Cholesterol						
Triglyceride						
H.D.L						
L.D.L						•
VLDV						
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Pa 47/Male/MHI202379692

Na 05/11/2023/гРH202302190

UH Dr.RAJESH.V



VITAL INFORMATION SHEET

MHI/IP/2022/074

Médway

Heart

Instituté

Every heart beat counts

ON ADMISSION

Height in CM Weight in Kg.

158 LM 69 - 25 - kg

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Every heart beat counts

Medway Hospitals®

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

Mr.SQMASUNDARAM M 47/Male/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V

VITAL INFORMATION SHEET

OPCAB & 2 GRAFIS

BSA:

BLOOD GROUP A POSUIVE ON ADMISSION 175m2 Height in CM Weight in Kg.

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47/Malc/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V





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	9-11		9-11
+8	<8 >96		<8 >96
Po2 Scale 1	94-95	1	94-95
xygen Saturation (%)	92-93	2	92-93
	<91	5	<91
po2 scale 2 oxygen aturation (%) use scale 2 target range is 88-92 % g: in hypercapnic espiratory failure only	>96 on oxygen		>96 on oxygen
se 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 >93 on air
Inician	>93 on air 88-92		88-92
	86-87	1	86-87
	84-85	2	84-85
	<83%		<83%
ir or Oxygen ?	A= Air O2litre/ min	1-0-1-2	A= Air O2litre/ min
	Device		Device Device
lood Pressure	>220		>220
	201-219		201-219
	181-200	1 2	181-200
	161-180 141-160		161-180 141-160
	121-140		121-140
	111-120		111-120
	91-100	1	91-100
	81-90		81-90
	71-80 61-70		71-80 61-70
	51-60		51-60
	<50		<50
astolic BP	mmHg		mmHg
ulse	>131		>131
eats / min	121-130	2 2	121-130
	101-110		101-110
	91-100	1	91-100
	81-90		81-90
	71-80 61-70		71-80 61-70
	51-60		51-60
	41-50	1	41-50
	31-40	THE RESIDENCE OF THE PARTY OF T	31-40
	<30	The second secon	<30
onsciousness	Alert		Alert Confusion
ore for New onset of	Confusion V		Confusion
nfusion	P	ASSISTANCE AND AND SOME OF THE PARTY OF THE	P
no score if chronic)	U	CARLOR BOARD ROOM THAT BEEN AND DESCRIPTION	U
	>39.1 degree	2	>39.1 degree Celsius
emperature	Celsius 38.1-39.0	1	38.1-39.0
egree Celsius	37.1-38.0		37.1-38.0
	36.1-37.0	10000	36,1-37.0
	35.1-36.0	1	35.1-36.0
TIME Total	<35.0	9 10 10 10 11	< 35.0
EWS Total lonitoring Frequency		THE THE CHE LOC LASS	
calation of Care Y/N	CONTRACTOR OF THE PERSON NAMED IN	72 14 70 70 70 70	
itials by RN		Par (1) 22 PC 200	
itials by Sr. RN		THE PROPERTY OF THE PARTY OF	

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

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



47/Malc/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V





irt beat counts

EARLY WARNING SCORE MONITORING CHART

Name:					_	Age	/Sex:_			P	Patient Io	1 No:	
NEWS key	DATE	8/4	9/4	914	9/11	9/11	9/11	6.00	10/11				DATE
	TIME	22.00	6-00	low	14.0	18.0	22,00	6.00	1400				TIME
A+B	>25			101		BASS		3			See See Se		>25
Respirations	21-24					1-		2					21-24
Breath/ min	18-20	-	-	-	• '	-		-	3		-		18-20
	15-17												15-17
	12-14												12-14 9-11
	9-11							1				_	9-11
	<8	1				-		3			Name and Address of the Owner, where	Name and Address of	>96
A+B	>96			*		-	-	1					94-95
SPo2 Scale 1	94-95												92-93
Oxygen Saturation (%)	92-93						-	2	-	District of the last	-	-	<91
Spo2 scale 2 oxygen	<91 >96 on oxygen							3					>96 on oxygen
spoz scale 2 oxygen saturation (%) use scale 2 f target range is 88-92 % eg: in hypercapnic respiratory failure only	>>o on oxygen												
use scale 2 under the	95-96 on o2							2					95-96 on o2
ection of qualified	93-94 on O2							1					93-94 on O2
nician	>93 on air	-	~	-	-	- 0		_					>93 on air
	88-92											-	88-92
	86-87							1					86-87
	84-85							2					84-85
	<83%							3					<83%
Air or Oxygen ?	A= Air	-	-	-1-	- 10	6	-	7					A= Air
an or Oxygen r	O2litre/ min							2					O2litre/ min
	Device											-	Device
C Blood Pressure	>220							3					>220
	201-219			-		-							201-219
	181-200							2					181-200
	161-180					-		-					161-180
	141-160										1		141-160
	121-140					-							121-140
	111-120		-				,	7			+		111-120
	91-100	-	-					1					91-100
	81-90							2		15 61			81-90
	71-80		-	-	1000000	1000000		3			No. of Concession, Name of Street, or other Designation, Name of Street, or other Designation, Name of Street,	THE RESERVE	71-80
	61-70							3			Salar Salar	RECORD BOYCE	61-70
	51-60							3			PERSONAL PROPERTY.		51-60
	<50							3				PARTY CANADA	<50
Name II - DD					-	The same of the sa		3					mmHg
Diastolic BP	mmHg		-				-	3				THE RESERVE	>131
ise	>131							2					121-130
ats / min	111-120							2					111-120
	101-110							1					101-110
	91-100							1					91-100
	81-90		_	-				1					81-90
	71-80			-	\.	, Am-	-						71-80
	61-70				-	-							61-70
	51-60												51-60
	41-50							1					41-50
	31-40	-		-	No.	100000		3		-	1000000	ALCOHOLDS	31-40
	<30							3			100000000000000000000000000000000000000	ALL DESCRIPTION OF THE PARTY OF	<30
)	Alert	4	-,-	- 5	-			-				200	Alert
Consciousness	Confusion		STATE OF THE PERSON		N. S. Phillips			3	E	TO SERVE	100 m		Confusion
core for New onset of	V							3				MANAGEMENT OF THE PARTY OF THE	V
onfusion	P	-						3		1977 199		STATE OF THE PARTY	P
no score if chronic)	U							3			PERSON		U
	>39.1 degree							2		THE REAL PROPERTY.	The same of		>39.1 degree Celsius
	Celsius						300	1			100000		
Temperature	38.1-39.0							1					38.1-39.0
Degree Celsius	37.1-38.0												37.1-38.0
	36.1-37.0		-10	-	-	- 0-	-	-+					36.1-37.0
	35.1-36.0			,				1					35.1-36.0
	< 35.0		Diego.	THE REAL PROPERTY.	1000		DECEMBER 1	3	20 Marie		ER SERVICE	76 60 20 20	< 35.0
NEWS Total		0	0	0	0	0	0	0					
Monitoring Frequency		Att	Ath	ohtz	CLM	413	Alb	Ath					
Escalation of Care Y/N		No	NO	M	N	24	NO	NO					
nitials by RN		40°C	D.C	81	2	177	19-5	Ci					
nitials by Sr. RN		100	200	109	100	1950	200	100					
	Note: Nurse	100	NIX	0.	10	1 - 54	124	1	1		1 1	1	

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



From:

Date



To: 6)1/63



Bed No: Gin-





MI.SOMASUNDARAM M

47/Malc/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V

14 **200** 100 1444 144 100 200 140 140 140 100 100 144 140 100 100

INTAKE & OUTPUT CHART

24 Hrs: Started Time: ずルめ **Ended Time:** NPO Started at: NPO Over at: **SHIFT** Morning Night Restricted Fluid (RF) Afternoon 500 ml INTAKE Too Me 950 ml OUTPUT 550 Mc Difference: 275 mp Total Output: 1500 m 225 ml Total Intake: **INTAKE** (ml) **OUTPUT (ml)** Intravenous Infusion Tube N/G Drain **Endorsed** Time Oral **Vomitus** R/N Sian Feeding Time Urine **Others** Aspirate Tube Type of Fluid Additions by **Amount** 11:00 14.20 1500 300 صوا 100 750 19.30 200 100 21-30 250 (00 D 2.30 1200 200 125.6.30 200 500 100 925 20030 200 1025 21-30 100 2330 200 1225 1225 ml PNTAKE 1500 ml TOTAL



47/Malc/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V







From: \$ 11112 To: 9 11 12 **Bed No:** Date **INTAKE & OUTPUT** 24 Hrs: Started Time: 19, 90 Ended Time: 7-00 **CHART** NPO Started at: NPO Over at: Restricted Fluid (RF) SHIFT Morning Afternoon Night Dow INTAKE **OUTPUT** 1100 Total Output: 8 500 Difference: 950 M 550 W Total Intake: INTAKE (ml) **OUTPUT (ml)** Intravenous Infusion **Tube** N/G Drain **Endorsed** Time | Oral Feeding Type of Fluid Time Urine **Vomitus** Others R/N Sign Aspirate Tube **Additions** by **Amount** 425 11.45 BUS App 11-45 400 525 10.00/100 14.20 600 to m 14.10 125 000 1720 4rd 1500 2100 19.00 600 16, 30 150. 800 2500 19-30 100 900 A00 00 · A t9.0d200 1100 21.00 100 1200 1400 22.00 200 1550 5.30 150 Ncea 0021 HATOT 1550m TNITAKE 2500 ml TOTAL UNDUL 950 HP BALLANC



47/Male/MHJ202375 05/11/2023/IPH202

Dr.RAJESH.V







Date	Fre	om: 9 11	a ₃ To	o: 10 u a 3	ß Be	d No: <i>[</i>	1W-4					INTAI		OUT	TIIG
24 Hı	s : S	tarted Time	1: 7.00		Ended T	ime : 🄫	<u>.00 </u>					IIAIWI			FUI
NPO	Start	ed at :			NP	O Over a	at :						CHA	AK I	
SHIF	T	N	Morning		Aftern	oon			Nigh	t		Resti	icted F	luid (R	F)
INTA	KE		45bml		50	10			00 ml						
OUTI			SSOW			0,10		140	omb						
Total	Intake	: 1950 A			otal Outpu	t: <u>185</u>	one			Differen					
			INTAKE				<u> </u>			ַרַטס	PUT	(ml)			
Time	Oral	Tube		nous Infusio	,		Time	Urine	Vomitus	N/G	Drain	Others		R/N Sign	Endorsed
A .	144.6	reeding	Type of Fluid	Additions	Amount					Aspirate	lube				by
230	200	<u> </u>				206	9.00	300					300		
lono	too					300							'		
11-30	150					450	Miles	250	-				333		
	28°C	,				tino	1300	hano					950		i
						, .		رس							
	<u>58−0</u>					840							17160		
85	10-C	\				950	20-20						d050		
20.30	200					1150	2.30	500					<u>d 550</u>		
22.30	300					1450	6.30	300					2850		
	300					1750									
o · 30						1950									
<u>, </u>										_					Naca
<u>-</u> -				_				-		701	7. T	NTAK	E - 10	50 M	2
		1	-									DUTDU	_		
<u> </u>		-										NCE -			DEC DE 0+



47/Malc/MHI202379 05/11/2023/IPH202:

Dr.RAJESH.V







Date To: 11/1/23 Bed No: G-W-4 From: 175 **INTAKE & OUTPUT** Ended Time: 7.00 24 Hrs : Started Time : 7-00 **CHART** NPO Started at: NPO Over at: **SHIFT Morning Night** Restricted Fluid (RF) Afternoon INTAKE 220W) **OUTPUT** From! **Total Output:** Total Intake: Difference: **INTAKE** (ml) **OUTPUT (ml)** Intravenous Infusion Tube N/G Drain **Endorsed** Oral Time Feeding Type of Fluid **Time Urine Vomitus** R/N Sign **Others** Aspirate Tube **Additions** Amount by 800 lob 2130 4.30 100 300 10.40 dop 3.30 150 do حويل 12.00 650 550 74.30 300 100 Total Intaka 550 m1 650 h Total output. Naa







Every heart best counts

Mr.SOMASUNDARAM M

47/Male/MHJ202379692 05/11/2023/PH202302190

Dr.RAJESH.V

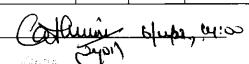


Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

nosis: CF	<u>U - PE</u>	D FF-61.	CARY E	SH MIL	.) .		
	cms \	Weight:Kg	Food allergi	les: Yes No, if y	es, specify	**************	
ous Beliefs:	: 🗆	Vegetarian	Non Veg	getarian		☐ Eggetarian	Jain
rescription	¥		DDH,			•	<u> </u>
JECTIV	E GLOBA	AL ASSESSME	NT (ADULTS)				
	(A) ·	Patient's related Medica	al History				
	1)	Weight Citange (overall r	change in past 6 months)				·
		U P	□ 2	D3			- 5
		No weight change/ gain	<\$%	5 - 10%		10 - 15%	>15%
21	Dietary Intake	Duration:					
			□ 2	a 3		0 4	D 5
	Oral 2	No change	Sub - optimal solid diet	Full liquid die moderate overall decre		Hypo - caloric liquid diet	Starvation
	Enteral / Parenteral Nutrition	Adequate / Excessive	Sub - optimal	Inadequate		Typo - caloric feeds	Starvation
3)	Gastrointestin	nal Sygnotioms Duration:					
		10:	□ ?	3		□4	- 5
		No symptoms	Nausea	Vorniting / moderate GI symptoms		Diarrhoea	severe anorexia
4}	Functional Cr	apacity (Nutripleth related function	nai impairment) Duration;			1.	
		D/	D 2	3		04	□ s
		None /Improved	Officulty with ambulation	Difficult normal		Light activity	Bed / chair - ridden with no or little activity
5)	Ca - mortsidity	(Disease and its relationship to n	sutrition requirements)				
		□ 1	□ 2			Let	□ 5
		Healthy	Mild co - morbidity	mort	lerate co - faidity/ age years	severe co - morbidity	Very severe multiple co - morbidity
B)	Physical exam	nination					
1)	Decreased fat	t stores or loss of subcutaneous f	fat		•		
		9	□ 2	_ ;		□ ′ 4	□ 5
	1 7	Normat	MId	Moderate			Severe
2)	Sign of muscle w	wasting					
		21	□ 2	□ 3		D4	□ 5
		Normal	Mild	Moderate			Severe
Total Score	= Sum f above 7 comp	ponents					<u></u>
				<u> </u>			
Nutritional 5	Status : Based on this	patient is					
	Well Nourished			□47 to 14)		<u> </u>	
	Moderately Mal	inourished		[15 to 18]	7	(D)	
	Severely Mainou	urished		(19 to 35)			
Nutrition inte	tervention:						
	Ors			☐ Enteral		arenteral	
Diet counse	illing provided:	₽/a		□ #o			
Frequency r	of re-assessment:	DAMES BY			☐ Fort - night	☐ Monthly	
		□ Dally			Calorie count: T Y		

Dietitian Signature / Name / Date / Time:



Mari

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
6/4/00, 14:00	A your ord now came & go @ Shoulder pain arrowalled with (1) will be well rounded on evident by	•
	Refer - RH/HTM Patrint shifted to Collected ruggy (ARM) and Kept on NOH. Patrint mind to sure. will initiate on diabeter; light dut as per docks admin.	Maria Catherine John (2017) Senior Dietitian
7944, 12:40	Roteint mind b step down us. NON ora. Portier benated diabeter; Girds wer. Can initiate a diabeter; and puster, soft roud dist.	Limite dedictine town (2) Senior Dietitian
8fulu, 14:00	Parmit <u>wind</u> b woud. Reemplijd on the dist wish this hustrated beart were.	Carlly (2401)
10:00	oral vitable in good. Put modification and clair cation down. Hostistud & eath user.	Colfui (2401)



47/Mulc/MH1202379692 05/11/2023/IPH202302190

Dr.RAJESH.V



Department of Dietetics



CARE PLAN FORM - A

DATE AND TIME DIETITIAN NOTES SIGNATURE 19/44, Chal intalm is good. Educated the patient and family on 1500 caloring.
19/4, Oal intale is good. Educated the
be for 100 rate, high prisons, diabeter of the discharge Emplied on small form from control Dies from model cation and clarification down pair chart grien on discharge





INTRAOPERATIVE NURSING RECORD

	Mr.SOMASUNDARAM M 47/Melc/MH1202379692 05/11/2023/IPH202302190 Dr.RAJESH.V	Consultant: Dr. RAJESH.
	Name of Surgery ! OPC	Date of Surgery: 06/11/23
	Mode of Transfer to OR	Bed Stretcher Other
	Anaesthesia Type	Epidural Spiral LOC MAC
		GEN Regional
5	Position	: Lithotomy Prone Supine Right Down Left down
		Lateral Other
	Pressure Protection Pad	·
		Headrest Sand Bag Fillow Axillary roll
		Shoulder roll
		☐ Sling ☐ Boot ☐ Stirrups/Leg Holder
		☐ L aem rest padded / Sccured ☐ R Årms tucked / padded
		□ Nil □ R □ L □ Other (Specify)
	Skin preparation in OT	Chlorhexidine Prep Providone Iodine Lodophor scrub
_		☐ Alcohol Prep ☐ Others (specify)
P	Electrocautery	: Monopolar Pad Loacation Dt upper aum. Bipolar
	Tourniquet	Location
		Applied Time Released Time
		Applied Time Released Time
		Applied Time Released Time Released Time
	Other equipment used	:
	Personal	: Surgeon Dr. Dayesh Dr. Droveer
		Anaesthetist D. Jeers Jasst. Dr. Proween
	Type of Specimen	:
	Lab	: Pathology Permanent Frozen Time sent
		☐ Cytology ☐ Time of report ☐ Microbiology ☐ Time sent
		Biochemistry

Packing / Drains / Catheters

Туре	Size	Site	Ту	pe	Size	Amo	ount	Sig	ţn
Romson's	28 Fr	It. Aluera					2		Menon
Pomeon's	22fx	medical	nun.				7	aln sa	031
Univary Sponge Court		rizection	Olono	by	BACK	+ US-R)	ér fole	y's Coullete
Count		Gauze Gauze Lined Unlined	Neuro Patties	Tonsil cotton balls	Vein Canula	Bulldog clamp	Needle	Circ. Nurse sign	Scrub Nurse Sign
Pre-op	Corred (men				Correct	Correct	Bys.	Sk 31
Change over count	N .	graph.		333		Correct	Corrord	By s	SU (3)
First closure count		riet				(grant	Concard	8.6	%
Final closure count	Check (- Jane 18			\searrow	Sucony	Comout	\$ /s	3/31
Count Corre	ect		_4						
Corrective action	on taken			/					
Surgeon inform									
Ster Dressing / Cast	le Ches Im mobil izer	t and H	cerd :	dress	sing	done	with	ne Meg	pera \$
Condition of pa					Fair	Crit			
Transferred to :	szw.		Patient R	loom 🗆	CCU	Reco	overy R	oom	
Scrub Nurse Sig	gnature Sh	2							
Name: $\mathbb{P}\int_{\mathcal{N}}$	SACJEUN	41R.							
Name : $\mathbb{P} \int_{\mathcal{N}}$ Date & Time :	06/11/23	. @ 13.1	55						
Circulating Nur	se Signature	8125							
Name; N									
Date & Time	6/11/23	@ 13:5	5						



47/Male/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V

1911 (M. 1884 (M. 1844 (M. 1884 (M. 1884 (M. 1884 (M. 1884 (M. 1884 (M. 1884 (M. 1884 (M. 1884 (M. 1884 (M. 1

PSYCHOLOGICAL WELLBEING REPORT

Date: [0.11.25]

Time: A ropm.

Unit: GW-4

Clinical diagnosis:

Surgery/ Procedure: PPCABG1

Impression: directed du to son's demisse

Pt feeling down of understands their cheat condition due to voor! dernier boy an accident tel, 25. It had reduced order since tel's 2 It also has incensed firancial breden. These could be the predispring factor.

Employee ID: MHIO275784

Signature of the Psychologist:





N 47/Malc/MHI202379692

U 05/11/2023/PH202302190

Dr.RAJESH.V





NURSING ADMISSION ASSESSMENT (ADULT)

Date of Admission:	her						
Accompanied by Relative: Yes No If Yes, Name of the Relative: Mes Heen A							
Relationship with Patient: LIFE Contact Person's Name: Relationship:	_						
Contact No.: 8939461060 Primary language spoken: Tamil English Indian International	ļ						
Interpreter needed: Yes Yo							
Patient status: Conscious Unconscious Disoriented Patient Vulnerable: Yes No							
Menstrual History : LMP : Menopause:							
Medical History: DM / HTM / Co - Morbility: Survey JL Yes If yes specify							
Drugs History: Antiplatelet (Specify) Art Stopped on 1/11/23							
Psychological Status: Calm Anxious Withdrawn Agitated Depressed Sleeping Difficulty							
Do you have any special religious, spiritual or cultural needs to be considered? Yes No							
If Yes, specify details:	-						
Socio Economic Status: Employed Retired Own Business Home-Maker Others:							
Vital Signs: Temp: Δ[¼] (°F) Pulse / HR: 72 (beats/min) BP: 130 /βο (mmHg)							
Respiration: (breaths/min) SpO ₂ : 98 (%) CBG: 							
Allergies / Adverse Reaction: Yes No Medication Blood Transfusion Food Novknow	n						
If Yes, specify:	_						
Pain: Yes No. If Yes, Score: Pain Scale Used: Wong-Baker FACES Pain Rating Scale (7-12 yea	ırs)						
Numerical Rating Scale (>12 years) CPOT (ventilator / comatos							
Duration: Location:							
Pain Character: Dull Aching Sharp Stabbing Shooting Burning Referred / Radiant Pain							
Nutritional Screening:							
Last 3 months Appetite: Increased Decreased No Change							
Last 3 months Weight: Increased Decreased No Change							
Type of Patient: Diabetic Non Diabetic Type of Diet: Diabetic Stet	_						
Dietician Informed: Yes No. If Yes, mention the Name: Mes Catheine Time: 1130	_						
Orient Patient if: Conscious Orient Patient Attendant if: Unconscious Disoriented	t						
Room Side Rails Toilet Bell Patient Information Board Bathroom Bed Contro	ols						
Use of Footstool Grab Bars Nurses Call Bell Television Grab Controls Telephone							
Functional Assessment:							
Particular Assessment Remarks Outcome							
Visual Impairment Yes No							
Hearing Impairment Yes No							
Chewing Difficulty Yes No	1						
Chewing Difficulty Yes No							

Daily Activity Of L	iving:								·· •
Activity	Activity Independent Assisted						De	pende	ent
Bathing									
Dressing		101							
Eating								$\overline{\Box}$	
Walking		- 行			$\overline{\Box}$	Ì		一百	
Toilet Use					Ē	1		Ħ	
Pressure Injury R	iek Aeses	sment: Brad	len Scale						
Sensory Percep		Score	Moisture		Score	Degra	e of Activi	h.	Score
No Impairment		4/	Rarely Mois	t	A		Frequently	•	; /4
Slightly Limited		3	Occasional		3		Occasiona		$\frac{\sqrt{4}}{3}$
Very Limited		2	Very Moist	<u>,</u>	2	Chair		,	2
Completely Limit	ed	1	Constantly	Moist	1	Bed F			1
Mobility		Score	Nutrition		Score	Friction	on & Shear		Score
No Limitation		4	Excellent		4 4		parent pro		/3
Slightly Limited		3	Adequate		\3		itial Problen		2
Very Limited		2	Probably In	-Adequate	2	Proble	em Present		1
Completely imme	obile	1	Very Poor		1				
Total Score:	High Risk: 12 - 10; Severe Risk: 9 - 6 Total Score: Action needed: Yes No Pressure injury present at the time of admission: Yes If yes, Location: Grade: Size: Witnessed by: Signature: Relationship:								
E II B'. I. A			E FALL ASSE	SSMENT SC	ALE (Age a	bove 16	years)		
Fall Risk Assess Variables	sment (MC	paitiea Mors	e Scale):		···			Ι Ν	neric <i>V</i> alue
							No	11441	0
History of falling	(immediat	e or within 6	months)				Yes	 	25
0				·			No		0 /
Secondary diagn	iosis (≥ 2	medical diag	inosis)				Yes		15
Ambulatory Aid									
None / Bed Rest		ssist							.0
Crutches / Cane	/ Walker							-	15
Furniture								ļ	30
Intravenous Ther	apy / Hepa	arin Lock / Tu	ıbes Insitu				No	╄	_0
							Yes		20
Gait Normal / Bed Re	st / Whaal	Chair							6
Weak	St / TTITCCI	Orian						1	10
Impaired					'				20
Mental Status	atabilit.								
Oriented to own Overestimated or		mitations						╂.	
	. ioigota iii							 	10
Medications Includes PCA / o						s,	No		O
laxatives, hypogi	ycemics, s	edatives, imi	munosuppres	ent and psyc	notropics		Yes		15
Score Interpretation	r: 0-24: Low	r-risk; 25-44: N	fedium Risk; Ab	ove 45: High F	Risk	Total Sc	ore	1	20

As per the score, tick the following appropriate	boxe	es:							
Familiarize the patient with the immediate surrounding Remind the patient to use call bell before getting out of Keep the two side rails in the raised position at all times Keep the call bell, bedside table, water, glasses within t Remove excess equipment or furniture to make a clear Keep the patient's bed in the low position at all times ex Feach fall-prevention techniques, such as sitting up for Bed wheels should be locked Encourage family participation in the patient's care Ensure that floor of the bathroom is dry and not slippen Review medications for potential side effects that can put the safety belts during movement in wheelchair The patients are not ambulated by themselves. They are Medium risk interventions (25 - 44) Apply all the low risk interventions Tie yellow fall risk tag in the bed and Wheel chair / Stretty Make sure that proper transfer precautions are instituted or wheel chair or on a toilet seat Use restraints and bed monitors as ordered by the doctor wheel chair or on a toilet seat Use restraints and bed monitors as ordered by the doctor wheel chair or on a toilet seat Use restraints and bed monitors as ordered by the doctor wheel chair or on a toilet seat Use restraints and bed monitors as ordered by the doctor wheel chair or on a toilet seat Use restraints and bed monitors as ordered by the doctor wheel chair or on a toilet seat Use restraints and bed monitors as ordered by the doctor wheel chair or on a toilet seat Use restraints and bed monitors as ordered by the doctor wheel chair or on a toilet seat Use restraints and bed monitors as ordered by the doctor wheel chair or on a toilet seat Use restraints and bed monitors as ordered by the doctor wheel chair or on a toilet seat Use restraints and bed monitors as ordered by the doctor wheel chair or on a toilet seat Use restraints and bed monitors as ordered by the doctor wheel chair or on a toilet seat Use restraints and bed monitors as ordered by the doctor wheel chair or on a toilet seat Use restraints and bed monitors as ordered by the	bed for all he pa path cept c a mod re to b cher uted for tor fects ment a restric ses' st riate) h then	tient's during ment ote fal oe am or hea level areas nd sh ctions	s easy reach g procedure before rising from the bed Is bulated only with assistance avy or debilitated patients in a of consciousness, gait and sower s mentioned above						
Initial Assessment to Special Needs and Vulnera	T	<u> </u>							
	Yes	No	Remarks (please specify)						
Terminally ill patients			,						
Patients with intense chronic pain	-	\succeq	· · · · · · · · · · · · · · · · · · ·						
Woman in labor or experiencing termination of pregnancy									
Patients with emotional or psychological distress									
Patient suspected of drug or alcohol dependency									
Victims of abuse and neglect									
Patients whose immune system is compromised									
Patient with infections and communicable diseases		/,							
Does the patient have implants									
Has tracheotomy been done									
Has colostomy been done		\square	,						
Any other potential needs of the patient		$ \mathcal{A} $							

	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 Active cancer (on-going treatment or diagnosed within 6 months or palliative care)								<u> </u>	Yes / No	Score		
1									or palliative ca	re) 			lo
2	Bedridden red	cently	>3 days or	r major	surç	jery w	ithin fou	ır weeks				Yes N	lo
3	Calf swelling (Assess for bo	>3 cn oth leg	n compare s)	d with	asyr	nptor	matic sic	de, measu	red at 10 cm l	pelow tibial tubercle		Yes / N	lo
4	Collateral (no:	nvaric	ose) super	ficial v	eins	prese	ent (Asse	ss for both	legs)			Yes 🖵 🔨	lo
5	Entire leg swo	llen (A	Assess for t	ooth le	gs)							Yes DA	to
6	Localized ten	dernes	ss along th	e deep	ven	ous sy	ystem (A	Assess for b	ooth legs)			Yes D	lo
7	Pitting edema	, great	ter in the sy	mptor	natic	leg (/	Assess f	or both leg	s)			Yes 🔲 N	lo
8	Paralysis, par	esis, o	r recent pla	aster ir	nmo	bilizat	tion of th	e lower ext	tremity (Asses	s for both legs)		Yes 🔲 N	lo
9	Previously do	cume	nted DVT (/	Assess	forb	ooth le	egs)	··				Yes 🔲 N	lo
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.								lo				
	Score Inter			babil	ity c	f DV	T):			<u> </u>	F	inal Sco	re
Tick	the score ob	taine	d (√)	√	′ [Action Take	en		Date	Time
Low	Risk	2	2 to 0		1								
Mod	lerate Risk	1	l to 2		İ								
Higl	n Risk	3	3 to 8										
Pers	sonal Belong	gings	/ Valuab	les:	-		·					•	
Valua	ables	D	escriptio	n		ith ient		Patient's endant		Signature of the atient's Attendant		Rema	rks
Dent	ures		pper□i. oth ☑N										
Hear	ing Aid		ight □Le il	eft									
	glasses / act lens	ΠY	es DN	0							<u> </u>		·······
Jewe	ellery	□Y	es 口N	0			<u> </u>				<u> </u>		
Othe (spec	r valuables cify)		<i>U</i>				<u></u>						
Rep	ort (List of X-	ray, E	CG, lab r	eport	s ret	aine	d with t	he nurse)	:				
Doti	ent /		Sign.			Na	me			Emp. No.	[Date	Time
	ent / ent's Attend	ant	کھا	00	77	<u> </u>	Mæs	Mee.	NA	Relationship WIFF	5	11/23	11.20
Nur	se		RI	<u></u>		↓_	Par	ithro		0072	\$\frac{1}{2}	1/23	11-20
Unit	Unit In-Charge 0005					04	11123	14:00					

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47/Male/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V



0005



Date: 5	nb3	Shift: ☐Morn	ing Evening Nigh	t		
S	Ventilator Periphera Ryle's Tul	s: CAD TVD PEWS Score: O day: al line day: Right: Left be: Yes No Day satheter: Yes No Day	PC Ce :: VII	cs: ISLE DD: ntral line days: P Score: ify organism:		
В	On room		A / n	te of surgery:		
A	Others: Pain Sco Fall Risk Braden S Pressure	ms: Temp: 974 (°F) Pulse (mmHg) SpO ₂ : 97 Pain Scale used Score: 2 Fall Risk Pro	(%) Height: \square (cms) : PIPPS / CRIES / FLACC / Notocol: \square Low Medium \square At Risk-Mild Risk: 18-15 \square SH): \square Yes \square No \square NA	Respiration:(brea Weight: £9, y (kgs) BMI:_ Wong-Baker FACES Pain Ratio High oderate Risk: 14-13 High Risk: Wound Dressing done: Ye Drains:	ng Scale / NR	
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: \(\textsquare{1} \)		_	-	
-		Signature	Name	Emp. No.	Date	Time
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Handover ta	aken by	5.Dx	5 Deuradhan	chini 0212	5/11/23	13.00
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NURSES PROGRESS NOTES								
Date & Time	C	Observations / Action	S	Signature with En	np. No.			
5/11/23	Alme	ision Notes						
11.00								
	- Patial	got admitted was	Je T	<u></u>				
	while adhing	ios petiest is		lostr-				
	In al achil	1. 01.L/2		1.014-				
-	- Tomosoon p	of stable						
	Mines on of	ION CATES						
11.60	- Putiat S/B	Dr. Anbarda sia						
	- Advised to	Jollou anaesthatist		Adh				
	order	0		<u> </u>				
		cleked & Recorded	l					
	- Investigations	cheked & Recorded enclosed						
12.3	-Patiat hand	led near to luce	Cros					
	duty Staff	led occito luen		lsln_				
	1 10							
					-			
					-			
	Signature	Name	Emp. No.	Date	Time			
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Patie Mr.SOMASUNDARAM M

Nami 47/Male/MHI202379692

UHID 05/11/2023/IPH202302190

DOB: Dr.RAJESH.V

DOA

Con: Mr.SOMASUNDARAM M

47/Male/MHI202379692

DF.RAJESH.V



Date: 5	11/23	Shift: Morr	ning Evening Night							
S	SITUATI Diagnosis NEWS / F Ventilator Periphera Ryle's Tul Urinary C	al line day: Right: Lef be: Yes No Day atheter: Yes No Day		days:						
В	Type of so Allergies On room	ROUND urgery: if any: NYDA air / oxygen: RA nts / New Symptoms in last s	Date of surg IV fluids on fl hift: —							
A	ASSESSMENT Vital Signs: Temp: 98 (°F) Pulse / HR: 70 (beats/min) Respiration: 20 (breaths/min) BP: 120 30 (mmHg) SpO ₂ : 98 (%) Height: 58 (cms) Weight: 9. 75 kgs) BMI: Others: Pain Score: 10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: 30 Fall Risk Protocol: Low Medium High Braden Scorer 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 No NA Current diet: DM Drains:									
R	Referral of Pending Pending Pending Critical vo Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders: instructions if any:	PNO. If Yes, modified care plan date	ÀBG						
. Ugeda	المعادلة	Signature	Name	Emp. No.	Date Tim	_				
Handover g		5. Dy	5 Douadhaushni	0212		1.3				
Handover t	aken by	F. Cate	F. Cathrine	0207	5/11/23 19-5	∞				
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NURSES PROGRESS NOTES									
Date & Time	Observations / Action	SI	gnature with Emp. No.						
5/11/22	Evoning Nuty Notes								
3.00	- Pt handing over taken from								
	morning buty staff.								
	= Pt conscious 5 ocionboard.		. <u>.</u>						
	= Pt US S Flo chart checked ?	pocodo	1.						
14.00	= pt Dup medication given og	· pa							
	Ding chat		5.0°						
	= p+ soon by projecthetic bocto	Ju.	0211						
	Accessment complete.								
16.00	= It Rhad sample collected &	Tont							
	18 Bitted stank								
	= pr preparation poro, cons	TNO							
	7 Pt VIS & I/o Chart checker	1= =	5.24						
18 00	Pormond.	- -							
<u> </u>	= Pt handing our gover to	-							
19.30	wight not and								
_	Torgan Sun								
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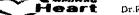
Patir	Mr.SOMASUNDARAM M
Nan	47/Mulc/MHI202379692
UHI	05/11/2023/IPH202302190
IOD	Dr.RAJESH.V
; D0	
Co _	



Date:	5/11/2	3 Shift: ☐ Morn	ing Evening Night		·
S	NEWS / P Ventilator Periphera Ryle's Tub	SECHO - DVD PEWS Score: © day: - Il line day: Right: - De: Yes No Day atheter: Yes No Day	∷ ← ∵ VIP Scc	line days: —	
В	Allergies i On room	ROUND urgery: if any: NKDP air / oxygen: Rp its / New Symptoms in last s	IV fluids	surgery: on flow:	
Α	Others :_ Pain Sco Fall Risk Braden S	ms: Temp: 9g m ^C F) Pulse	_	ight: <u>[ᠫ4-25(</u> kgs) BMI: <u>c</u> g-Baker FACES Pain Rati h	ng Scale / NRS / CPOT
R	Referrat of Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders:			from lamn
Llandar	.i	Signature	Name	Emp. No.	Date Time
Handover g	-	F-lati	F. Cathrine	0207	6/11/23 7.30
Handover to	aken by	Xox	Pacyllon	002_	6/11/23 73
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	NU	JRSES PROGRESS NOTES			
Date & Time		Observations / Action		Signa	ture with Emp. No.
5/11/23@		GHT DAY NOTE:	S		
19.30	night duty	anded over taken	by	Free	201
	- Inst consult	ous oriented itals segns checked	p		
20·30	Depatient drugs are	had diet, Pation	t due	£. ()	ati of
22.00	⇒patient vie	tals signs Checked	12	F.C	ati
98·30	=> partient h	ad Broad & milk	-	0%0	<i></i>
3.00	rocorded	sitals signs then	Ked 2	E. (a#9
6.00	⇒ patient v becorded ⇒ patient T/	itels signs Checke	d Z	F. (atj
7.30	=) patient duty staff	handed over to m	orning	£.0	at o
D	Signature	Name	Emp. No.		Date Time
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47/Malc/MHI202379692



05/11/2023/IPH202302190





MHI/NUR/2022/048

	NURSES PROGRESS NOTES							
Date & Time	Observations / Action		Signature with	n Emp No.				
	CTOT RECEIVAL REPORT							
	Patient Received From 9 w I To crof With Blue Op File A	And Case						
	Sheet ECG: U ECHO: U X-RAY: ANGIO CI	n. 201,		·······				
<u> </u>		J: 1-,						
06/11/23	CT FILE:		Syathe	A				
(0)	Patient Posted For Procedure: OPCAB (CH)		De la como	725				
9:35	Under Anesthesia: J. G.A.							
	Allergy Status: Not known							
	Known Case Of: Asis, CAD, TUD, WOMAL BOY, SHOPN.	- rn'Et	- 61%,					
	Past Surgical History:							
	VITAL SIGN: TEMP: 42 F HR: 92 blant SPO2: 987. BP 15	olizo me	ч9.					
	CTOT SHIFTING REPORT							
	Patient Shifted From ST-OT To SICO. With Blue Op Fil	le And						
	Case Sheet Along With *Surgery Safety Check List							
	*Intra Operative Record							
06 11 23	*Nurses' Record *			.a. #				
	ECG: (1) ECHO: (1) X-RAY: (1) ANGIO CD): NC	Sign.	12				
13:55	CT FILE: NI							
	Patient Posted And Underwent For Procedure: OPCAB	24 1.						
	Under Anesthesia: UGA Procedure: OPCAB CHILL RADIAL SOM.							
	Drain tube size and placement: 2 b fr.							
	Pacing wire placement: Present/Absent Site: NIC.							
	Implants: ריי ייי וא Decomption of the control of t							
	Cautery burn/skin peeling/towel clip mark: Present/Absent Site:							
	VITAL SIGN:							
	TEMP: HR: SPO2: BP:							
	Notes:							
	Notes: Blood group -> ATHE Hb. 12 ame, 1 Ope	w Roser	ved .					
	Signature Name	Emp. No.	Date	Time				
Document endorsed by	Sycitha A SUTATHIA A	120	- 06/11/2	3/2, 15				

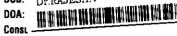




Patie Mr.SOMASUNDARAM M

Nam 47/Male/MHI202379692 UHID 05/11/2023/IPH202302190

DOB: Dr.RAJESH.V





PATIENT CLINICAL HANDOVER RECORD FOR NURSES								
Date:	6/11/2	Shift: Morr	ning Evening Night			,		
S	SITUAT Diagnosi: NEWS / F Ventilator Periphera Ryle's Tu Urinary C	ION s: CAN TO P PEWS Score: O r day: al line day: Right: Lef be: Yes No Day Catheter: Yes No Day	r: VIP Score:	days:				
В	Type of s Allergies On room	ROUND urgery: if any: 以k Din air / oxygen: パロ nts / New Symptoms in last s	Date of surg IV fluids on fl hift: が「					
A	ASSESSMENT Vital Signs: Temp: 11(°F) Pulse / HR: 18 (beats/min) Respiration: (breaths/min) BP: 130 (mmHg) SpO ₂ : 97 (%) Height: 18 (cms) Weight: 47:2 (kgs) BMI: 27:7 kg / N/2 Others: Pain Score: Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT: Fall Risk Score: Fall Risk Protocol: Low Medium High Braden Score: Minimal Risk: 23-19 At Risk-Mild Risk: 18-15 Moderate Risk: 14-13 High Risk: 12-10 Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): Yes No NA Wound Dressing done: Yes No NA Current diet: NA							
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 g	given by	O X	Doller	0082_	6/11/22	9-2		
Handover t	aken by	4 0	-Shifted 407.		(
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	NU	JRSES PROGRESS NOTES			
Date & Time		Observations / Action	Sigi	nature with Emp.	No.
7-3-		ing data Noto			
	- while take		right for	gy.	
	- Wo from - No from - 10 per so				
9:10		Hiry Notes			
	- Acc le wels	g lepats hand	Pacal	Poln	
	CAG CD	is will petiet a	flenda fe	Str.	
	Signature	Name	Emp. No.	Date Ti	me
Document endorsed by	Noe	g Nalin	00Q L4	6/11/83 92	Ø





47/Male/MHi202379692 05/11/2023/IPH202302190

Or.RAJESH.V





Shift: Morning Evening Night SITUATION Diagnosis: MD-TVD NEWS / PEWS Score: POD: Do S Ventilator day: Peripheral line day: Right: Left: VIP Score: DUS Ventilator day: Yes No Day: VIP Score: DUS Urinary Catheter: Yes No Day: VIP Score: DUS Urinary Catheter: Yes No MDR: Yes No. If Yes, specify organism: BACKGROUND Type of surgery: CDCAB x 2 4 RAFTS Date of surgery: 6(11/2 3 Allergies if any: On room air / oxygen: DN , O2 MOSILE 5 64 F Complaints / New Symptoms in last shift: ASSESSMENT Vital Signs: Temp 4 PP Pulse / HR: S (beats/min) Respiration: 15 (breaths/min) BP: 1 13 (mmHg) Spo.: 10 (%) Height 3 (cms) Weight: TO (kgs) BMI 7 T kg m 2 Others: BSA 1 15 m2 Pain Store: VID Pain Scale (NRS / CROS)						
Type of surgery: Opcab x a y RAFTS Date of surgery: 6(1)(23) Allergies if any: On room air / oxygen: bN , 02 Moste is 660 IV fluids on flow: CABILUT C- Complaints / New Symptoms in last shift: ASSESSMENT Vital Signs: Temp: 1 O°F) Pulse / HR: 1 (beats/min) Respiration: 15 (breaths/min) BP: 1 1 13 (mmHg) SpO ₂ : 100 (%) Height 15 (cms) Weight: 10 (kgs) BMI 27.7 Ly m 2 Others: BSA - 1.75 m2						
Vital Signs: Temp (%F) Pulse / HR: (beats/min) Respiration: 15 (breaths/min) BP: 14132 (mmHg) SpO ₂ : 100 (%) Height (53 (cms) Weight: 10 (kgs) BMI (37.7 kg m 2) Others: BSA - 1.75 m2						
Vital Signs: Temp: 44-1°F) Pulse / HR: 15 (beats/min) Respiration: 15 (breaths/min) BP: 14133 (mmHg) SpO ₂ : 100 (%) Height 53 (cms) Weight: 10 (kgs) BMI 27-1 kg m 2						
Special instructions if any: Signature Name Emp. No. Date Time						
Handayar alyan by A Dalish						
Handover taken by MAHALAKSHMI M DAIQ 0/11/23 19.30 Handover taken by Ania FLARANCE DO A 611/23 19.30						
Document endorsed Q-Nalini 0004 61,193 20'n						

	NU	JRSES PROGRESS NOTES			
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	puses det.				
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	Isay tanen				-
6:30		slept contostab	-	.	
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17-40	Znj: Cofu	soaine 15 gm ad	whester	1. Males	
	as ordered.	· · · · · · · · · · · · · · · · · · ·			
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	patient. 120	utent conduition is a	Hobby.	08/9	
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	duly state wi	th stable conduction.			
					
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47/Malc/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V





PATIENT CLINICAL HANDOVER RECORD FOR NURSES									
Date: 6	11/23	Shift: Mo	orning Evening 1	Vight					
S	NEWS / F Ventilator Periphera Ryle's Tu Urinary C	s: (A) - VV PEWS Score: - r day: - al line day: Right:(U) A be:	Left: DI Day: — Day: I MDR: ∐Yes ∏Mó. If Yes, s	GCS: IF IF POD: TOOS Central line of VIP Score: Cospecify organis	days: 10				
В	Type of s Allergies On room	ROUND surgery: OPCAD if any: NKDA air / oxygen: ON Outats / New Symptoms in las			ery: 6/11/0/3 ow: KABILY	TE			
A	ASSESSMENT Vital Signs: Temp.91.3 (°F) Pulse / HR: 8.3 (beats/min) Respiration: 16 (breaths/min) BP: 160 8 (mmHg) SpO ₂ : 100 (%) Height: 168 (cms) Weight: 10 (kgs) BMI: 17 Floor Others: 2 P Sign Ho								
R	Referral Pending Pending Pending Critical v Changes Pending	medications: medications: medication indent: lab reports / Investigation ralue alert and its corrections in nursing care plan: follow-up orders: instructions if any:	s: ns:	care plan date	o:		,		
	1	Signature	Name		Emp. No.	Date	Time		
Handover		(Par)	GONTA FLORANC	<u>E.</u>	00-94	7/11/23	ਜੈ <i>'00</i>		
Handover	taken by	Maha>	MAGACALESHM	11-11	Dala	7/11/23	7.00		
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NURSES PROGRESS NOTES								
Date & Time	(Observations / Action		Signat	ture with E	mp. No.		
1/12	Jook over the	2 patient in a hoome	0-		<u>-</u>			
6/11/03	dynamically moint	arning consistion withou	ytt			. <u>. </u>		
19-7-00	Supports.							
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	afabrile.			RING	guis/or	^A		
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21.00	Que Madola	flew grow.	_					
21.15	Nobelization	grow with lardin	0.63mg			<u>.</u>		
	and spironalry	Children .		RNO	bus 100 \$	4		
\$5.00	back care	givoer. Ofken Entrot.	-	, \				
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	Convego Support				[4		
	Signature	Name	Emp. No.		Date	Time		
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47/Male/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V





Date:	h123	Shift: Morr	ing Devening Night				
S	Ventilator Periphera Ryle's Tul Urinary C	S: AD TVD PEWS Score: day: UPTAL Il line day: Right: be: Yes No Day atheter: Yes No Day	v: VIP Score:	ols			
B		urgery: OPCABX 24	(IV fluids on fl			•	
ASSESSMENT Vital Signs: Temp: 97-4 (°F) Pulse / HR:							
R	Referral of Pending Pending Pending Critical von Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	No. If Yes, modified care plan date	o:			
		Signature	Name	Emp. No.	Date	Time	
Handover (No.	MACHACHUSUMI-M	0219	7/11/23	विन्द्रेय	
		Mario	6. Nalini	6890	7 1123		
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	NU	JRSES PROGRESS NOTES				_
Date & Time	(Observations / Action		Signat	ture with E	mp. No.
7/11/23	Mornine	y Duty REPORT	- <u></u>			
7.30	l <i>b</i>	estere parcent in				
		my Stable with	U //			т
	ı v	one toceing vitals 8	,			
	Bh CRO, lung	s clear, Abdomen	<u>G</u> .	M	uli	
	Got poul	Sound Good perip	reues			
	wasn and pulses	felt.			_ ^	
Pero .	paris	ent had itsod ou	celly		de la companya della companya della companya de la companya della	
	and talesated c	vell:	<i>J</i>		(4)	
8:30-	. Admin	istored due drugs	cy	MAC	ho	
	per oudes.	·		100	5W 	
9.00	JB DR.	Ambarery and to	our			
	Aduica for	Icu-I Shifting. T.A	reto	Mo	orly	
	malal Donig a	rddel.		· · · · · · · · · · · · · · · · · · ·	<u> </u>	
9.50.	Left	pleural & Medias	inad	· U	9/195	
	drais removed.			'' 1	90° 	
10:30	Assessial	line removed.	. : '	ور	119-	
11.30.	Doublent	shifted to SDELL	<u>^</u>		, 	
	luith steeble	condition.		·Mo	<u> </u>	<u> </u>
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PE MI.SOMASUNDARAM M

Ni 47/Male/MH1202379692

UF 05/11/2023/FPH202302190

D(Dr.RAJESH.V DC





7/11/23 2010

0024

PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 井ႃ/ ₁	1/23	Shift: Morr	ning ☑Evening ☐Night					
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CAD TUD PEWS Score: day: line day: Right: WBITALeft be: Yes Mo Day satheter Yes No Day		days: D ₂				
В	Allergies On room	ROUND urgery: ORABg えらに if any: NKDA air / oxygen: の にのm o nts / New Symptoms in last s	∑ IV fluids on fl	ery: 6/11/23 low: —				
A	ASSESSMENT Vital Signs: Temp: 97 (°F) Pulse / HR: 34 mm (beats/min) Respiration: 18 mm (breaths/min)							
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 t		Jo:	Salling Vani	0139 0265	7/11/23	1938 1930		

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	NU	JRSES PROGRESS NOTES		
Date & Time		Observations / Action		Signature with Emp. No.
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12.30	Took over	the patient wi	a	
		ally Stable word		19 Eug
	wP-thout su	ippost on month	orwig	as c
	HR- 48bpm, E	SP-102/62mm Hg, Spo	2-93/.	
	On stoom Ab	i.nasal paongs 6111	Jo) .	
12.45	Patient ha	d hypotension 181	P- 80/42	
	mmttg) Kabily	te 200ml guer	as	10 Jame
	per cords			O(87
13.30	Patient stook	wal and stolera	ted	In Puig
	well			0135
14.∞	Due medic	cation was admint	stered	
	as per order	,		
15.00	Paovided	comfortable positi	200	Mesura
16.00	Admintedage	d Nebulgation	and	01399 .
	Sp. vio metry_	oxerañ as per	cade.	
17.40		ie 1-5gm as pac		19 Onja
18:00		11	from	0137
	bed to chai	λ		
18-15.	Patient o		B	10/20
	rusit the	patient and expla	irod	70.00
	about remove			937
19-15	Patient an	d patient support	was	Rio_
	handled on	er to night		10 Chart
	duty staff			
			-	
	Signature	Name	Emp. No.	Date Time
Document	Signature N coan	e. Nalini	1	1 1-7 1-
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47/Malc/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V





Date:	Shift: Morn	ing □Evening ☑Nig	ht	.1020
NEWS / Ventilato Peripher Ryle's Tu Urinary (is:(AD-TVD PEWS Score: — r day: — al line day: Right: 〇四年上eft ɪbe: ☐ Yes ☐ No Day Catheter: ☐ Yes ☐ No Day	P C + D2	CS: 15/15 OD: I entral line days: D2 IP Score: 0 5 cify organism:	
B Type of s Allergies On room	iROUND surgery: OPCABX 3GF if any: NE air / oxygen: ON 02 & nts / New Symptoms in last si	R Lit IV	ate of surgery: 6 11 23	
Vital Signal BP: 116 Others: Pain Sc. Fall Risk Braden Pressure	2 o (9 2) mmHg) SpO ₂ : 9 to SSA - 1.7 m ² ore: 2 to Pain Scale used of Score: 50 Fall Risk Pro	. (%) Height: S (cms 	n) Respiration:	ing Scale / NAS / CPOT
Referral Pending Pending Pending Critical v Change Pending	doctors: medications: medication indent: lab reports / Investigations: value alert and its corrections: s in nursing care plan: Yes follow-up orders:		e plan date:	
Handayar abran bu	Signature	Name	Emp. No.	Date Time
Handover given by Handover taken by	D. Sheeba	Sothiya Vani D. Sheetro	0265 0270	08/11/23 7.20
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NURSES PROGRESS NOTES						
Date & Time		Observations / Action		Signat	ture with E	mp. No.
71122	Took over the	patent in heamod	lyng-			
19:20	mically stable	condition deable e	endition	ار	Cattya ce	
	with nill Sy	sports. Palient is			U ass	
	Conscious and	oriented.				
20:10	Patrent had	food orally and				
	well loterated	1				
20:20	Medicines are	given as per orders				
21:50	Reprometory e.	xercise and Neb.	evolin			
	given for pal	cent.		<u> </u>	ating 100	
23:00	Borided confort	able position for patre	~f			
1:50	Position change	0.		_		
4.30	Bood Sample	taken and Sent le	lab.			
4:45	Remonee V-cat	h as per order.				
5:00	Oral case gin	in with paste & bound	<u>sli.</u>			
5:20	Bed bath an	I back care given		<u> </u>	tuy	
	with anyses	V			<u> </u>	
\$ 140	Sjarometery e	· · · · · · · · · · · · · · · · · · ·	alion			
	given for patie	nt.		 ·		
6:50	Klobilised the	, , , , , , , , , , , , , , , , , , ,				
T: 80	chedeed CB	1		٤	atura	
7:20		the patient to	<u> </u>			
	morning duty	Stoff.				
<u> </u>	-					
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	Signature	Name	Emp. No.		Date	Time
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Patient De

Mr.SOMASUNDARAM M 47/Male/MHI202379692 05/11/2023/iPH202302190

Name: UHID: DOB:

Consultant:

DOA:

 Heart Institute

j heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NURSES							
Date: a	8/11/03	Shift: Mori	ning Evening	Night			
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	al line day: Right: ເພື່ອກັນLei be: ☐ Yes ☐ Mô Day atheter: ☐ Yes ☐ Nó Day	y:	Central Tine o	POD days: D3		
В	Allergies On room	ROUND urgery: OPCHB x 2 UN if any: NEDH air / oxygen:ON ROOM nts / New Symptoms in last s) His	Date of surg	ery: 06/11/c)3	
A	ASSESSMENT Vital Signs: Temp: 98-1°F) Pulse / HR: 100 (beats/min) Respiration: 22 (breaths/min) BP: 130 6 (mmHg) SpO ₂ : 92/(%) Height: 10 (cms) Weight: 10 (kgs) BMI: 11-1 (pm²) Others: 800 - 1, 1 m² 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 Migh Risk: 12-10 Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): Yes No No No Drains: Drains:						
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: instructions if any:	<i></i>	care plan date	:		
		Signature	Name		Emp. No.	Date	Time
Handover	- •	D. Sheeter	D. Sheel) a	0270	108 his	12-30
Handover to Document	<u> </u>	Nue Nue	2. Nalin	nini _	00 \$77 © 140	8/11/23	12.30
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NURSES PROGRESS NOTES						
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	dusty St	aff. Pt is		Clube		
	Conscious	and one	nted.	2000	·	
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	haramadynas		D. Pt.			
	w on	Room Air, Hi	2-981		·	
	BP-130/60 (7)) mm+19, lpo, -	92%			
9.00	* pt	lad Food	and			
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11.45	* Pt	is Consciou	Q			
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	monitornal	. 26 chart				
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Patient Details (Affix Label here)

Name: MR OOVED N DATE

UHID: 2023 79 97

DOB: Sex.

DOA: Sex.

Consultant: R PATES 6



Every heart beat counts

Date:	Shift: Morr	ning DEvening Night					
Ventilator Peripher Ryle's Tu Urinary 6	PEWS Score: PEWS Score: or day: ral line day: Right: Cubil Lef ube: Yes No Day Catheter: Yes No Day	POI Cen V: VIP	s: 5 5 5 core: 0				
B Type of a Allergies On room	SIROUND surgery: TEABX 2(s if any: NKOA n air Loxygen: On Roo ints / New Symptoms in last s	matr IVIII	of surgery $6 11 23$.				
Others: Pain Sc Fall Risi Braden Pressure	ASSESSMENT Vital Signs: Temp (F) Pulse / HR: (beats/min) Respiration: (breaths/min) BP: 120 (mmHg) SpO ₂ : 93 (%) Height 8 (cms) Weight: 10 (kgs) BMI: 11 (kgs)						
Referral Pending Pending Critical Change	mmendation doctors: g medications: g medication indent: g lab reports / Investigations: value alert and its corrections es in nursing care plan: Yes g follow-up orders:	/ /	olan date:				
Handover given by	Signature	Name	Emp. No.	Date	Time		
Handover taken by		M. Down H.	0725	8/4/23	19.30		
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NURSES PROGRESS NOTES								
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16.00		forordod ion guien ces cart Lation quien	Per I					
1830	patient The patien	Chart Monitore						
[q. 3s	-p patient	harding ox	er) *				
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Patir	MI.SOMASUNDARAM M
Nan	MH120237907#
UHIL	05/11/2023/IPH202302190
DOB:	-0111/
DÔA:	Dr.RAJESH.V
Const	HI HI HI HI HI HI HI HI HI HI HI HI HI H



Date: 🎗 📊	Date: 8 11 2 3 Shift: Morning Evening Wight								
S SI Di NI Ve Pe Ry Ur	ITUATI iagnosis EWS / Pentilator eriphera yle's Tut rinary C	s: CAD_T VD PEWS Score:_ day: - I line day: Right: Cubi lotef De:	<i>i</i> :	GCS: SISIS POD: II Central line days: ~ VIP Score: OIS specify organism: —					
B	vpe of su llergies i n room	ROUND urgery: OPCABX241 If any: NKDA air / oxygen: ON 160000 ts / New Symptoms in last s	avi	Date of surgery:	11123				
Pi A Pi Bi	ASSESSMENT Vital Signs: Temp: 967(°F) Pulse / HR: 85 (beats/min) Respiration: 20 (breaths/min) BP: 12 0 7 0 (mmHg) SpO ₂ : 95 (%) Height: 158 (cms) Weight: 70 (kgs) BMI: 27-7 Kg/m² Others: Pain Score: 10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NDS / CPOT Fall Risk Score: 50 Fall Risk Protocol: Low Medium Migh Braden Score: 10 Minimal Risk: 23-19 At Risk-Mild Risk: 18-15 Moderate Risk: 14-13 High Risk: 12-10 Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): Yes No NA Wound Dressing done: Yes No NA Current diet: Orains:								
RECOMMENDATION Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: Critical value alert and its corrections: Changes in nursing care plan: Yes No. If Yes, modified care plan date: Pending follow-up orders: Special instructions if any:									
Handover give		Signature	Name N. Rovath	Emp.	No.	Date 9 1 23	Time 7.36		
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	NU	JRSES PROGRESS NOTES			,
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at					·
19.30	⇒Pt hand	groy taken to	the		
	evening duty	staff.		10555	
	= Pation	Conscious & Ori	entod.		
		avo Stable.			
	=> hemod	yramically stable	<u>D.</u>		
20.00	sh Pt ho	nd a Diabotic a	dict	<u> </u>	
,		tion given as		- 1	
	as doug a	hasit		MOVE	
21.00	36 Pt 41	ood mobilized			
	=6PE wx	as stable & NO ho	ave		
	complaints	<u></u>			
22.00		ization was gi	ron.		
00.00	as Pt &	yogol sleep.			
4.00	=> Poetion	1 is slooping u	000/.		
6.00	= Nopuli	Eation uns give	on.	10005	
	=> vitals	chockeds recos	rdog/		
	= T10 C	hard mondproor			
7.30	== PE ho	und ovon given by staff.	to the		
-	morning dut	by staff.			
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<u>.</u>		Г.,	<u> </u>	T <u>4</u>	I
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Mr.SOMASUNDARAM M Na 47/Male/Mri2023/2190
UH 05/11/2023/19H202302190 47/Male/MHI202379692 DO Dr.RAJESH.V Cos.



PATIENT CLINICAL HANDOVER RECORD FOR NURSES								
Date:	9/11/0	Shift: Morn	ing Evening Night					
S	NEWS / P Ventilator Periphera Ryle's Tul Urinary C	s: (AD - TVD) PEWS Score: — day: — Il line day: Right: D to Left be:	r: VIP Score:€	days:				
В	Allergies of On room	ROUND urgery: OP(ABメ2の if any: NLDA air / oxygen: RA ats / New Symptoms in last s	IV fluids on f	nery: 6 /11/23				
A	ASSESSMENT Vital Signs: Temp: (°F) Pulse / HR:							
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	No. If Yes, modified care plan date	Đ:				
	_	Signature	Name	Emp. No.	Date	Time		
Handover g	given by	5.93	5. Douadrachini	0212	9/11/22	12.30		
Handover t	aken by	82	el Devila	D18L	9Mh	1280		
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	NU	JRSES PROGRESS NOTES		_		
Date & Time		Observations / Action	-	Signat	ture with E	mp. No.
9/11/23	Mori	ring Duty Notes				
7.30						
	- Patrat de	ika over from	might	—-X	Doffa_	
	data Saff	Qua potet 7's				
	Leans dy Man		-			
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8 · 3 -	Dee medic	ctions given as	per	fox	la	
840	- patiet 8/8	Dr. An barasu si				
	P _	6 Sature reason		2		
-	& inustigations discharge	poday	-	Yu	3/2-	
	0					
9.00	- Siture son			Pet	1/2	
12.45	- Vital signs	X- Ray done	led	Payl	<u>, </u>	
13.00	- Ontiat ha	ded ones to ene			<u></u>	
	dely Staff		8	Asla		
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-	Signature	Name	Emp. No.		Date	Time
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Pa MI.SOMASUNDARAM M

Ni 47/Malc/MHi202379692 UF 05/11/2023/IPH202302190

DC Dr.RAJESH.V





Every heart beat counts

Date: 9	1112>	Shift	t: Morr	ning Evening [Night		J11020	
S	SITUATI Diagnosis NEWS / F Ventilator Periphera Ryle's Tul Urinary C	ION S: CAD -7 VI PEWS Score: O'day: — al line day: Right:	_ Lefe PNo Day	t: —	GCS: 点り POD: 加 Central line o	days:-		
В	Allergies On room	ROUND urgery: OPUPI if any: air oxygen: O its / New Sympto	A Pean	dir.	Date of surg	ery: 6(11/2) ow: -		
A	BP: 128 Others: Pain Sco Fall Risk Braden S Pressure Current of RECOM Referral of Pending Pending Pending Critical via Changes Pending	INENDATION Control of the control o	Scale used all Risk Pro Risk: 23-19 [Idealing (PUS) Int: stigations: corrections: clan: Yes	/ HR: // () (beats, / (%) Height: 155 (c) : PIPPS / CRIES / FLACetocol: Dow Medi Dat Risk-Mild Risk: 18-15 SH): Yes No No No	cms) Weight: CC / Wong-Bak um	(kgs) BM ker FACES Pain R sk: 14-13 High R Dressing done: s:	ll: <u>2</u> ⊒.⊯)(y) lating Scale / NR lisk: 12-10∐Sever	
	•	Signature		Name		Emp. No.	Date	Time
Handover g	iven by	8		Il Doi	i)s	Obr	9/mr	193
Handover ta	aken by	MIL		N. Rorath	î	0225	9/11/22	19.20
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NURSES PROGRESS NOTES							
Date & Time	(Observations / Action	Sig	nature with Emp. No.			
9/11/2		-voning roce.					
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(<u>) ve</u> v	-> patient h	eard over tector 8	<u>xoun</u>				
	morning du	ty Steeff		··· <u>·</u>			
	J			8			
10551	-> partient	is steblo Enital	cogs	de			
	check romocy						
14.00	-> patient	Modicition given	as				
	pan dung	Chord rounds		l			
16.00	-> pati	ent 7/10 Chest no	D. W.				
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17-0		tient no compact					
18-71	•	tient To Chart					
19-10	Spritio	nt Goenal Due	tur-				
	to Nieght	-dul-					
 							
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	Signature	Name	Emp. No.	Date Time			
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" MI.SOMASUNDARAM M

47/Male/MHI202379692

UH 05/11/2023/IPH202302190

DO Dr.RAJESH.V





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Cor

	PAHE	NI CLINICAL F	IANDUVER RECOR	D FOR NOP	13E3	•
Date: Q	ાાંગ્ર	Shift: Morn	ing Evening Night			
S	NEWS / F Ventilator Periphera Ryle's Tul	S:CAD-TVD PEWS Score: day: - Il line day: Right: Left be: Yes No Day atheter: Yes No Day	: VIP Score:	days: _		
В	Allergies On room	ROUND urgery: OPCAB X2 U if any: (N (ND) air) oxygen: ON TOOM its / New Symptoms in last sl) Ob1 IV fluids on fl	ery: 6[u]23 low: -		·
^	BP: 130 Others :	ns: Temp 1 (°F) Pulse) 180 (mmHg) SpO ₂ : Q	/ HR: (beats/min) Respira (cms) Weight: : PIPPS / CRIES / FLACC / Wong-Bal otocol: LowMediumHigh	(kgs) BMi:	27.719/	_
A		Ulcer Scale for Healing (PUS	Drain	Dressing done: ☐ Yes		9 Risk: 9-6
R	Pending Pending Pending Critical vi Changes Pending	medications: medication indent: lab reports / investigations: alue alert and its corrections: in nursing care plan: Yes* follow-up orders:	Tho. If Yes, modified care plan date	•		•
		Signature	Name	Emp. No.	Date	Time
Handover ç	given by	MP	M. Revathi	0225	10/11/23	7,20
Handover t	aken by	A	Agusthiya	0116		8.60
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Pali Mr.SOMABUNDARAM M Nan 47/Male/MHJ202379692

UHI 05/11/2023/IPH202302:90

Dr.RAJESH.V





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Date: 10	ીમાં ક	3 Shift:4 Morn	ing Evening Nigh	l .		
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В	Allergies i On room	ROUND urgery: ON PO P if any: NO PO P air / oxygen: ON YOOO its / New Symptoms in last s	ng au'r IV fi	e of surgery: 【【【】 guids on flow:	•	
A	Others: Pain Sco Fall Risk Braden S	re: OP Pain Scale used Score: Minimal Risk: 23-19 Ulcer Scale for Healing (PUS	LA(%) Height: \(\overline{5}\) (cms) : PIPPS / CRIES / FLACC / Votocol: \(\overline{1}\) Low \(\overline{1}\) Medium \(\overline{1}\) At Risk-Mild Risk: 18-15 \(\overline{1}\) Medium \(\overline{1}\)	Weight:(kgs) Wong-Baker FACES Pa High	BMI: 2 ਹਾਂ ਸਾਂ ਹੈ in Rating Scale / NB gh Risk: 12-10 ☐ Sever	S CPOT
R	Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:	_/_	plan date:		
L		Signature	Name	Emp. No.	Date	Time
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	NURSES PROGRESS NOTES	
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	to the patient attender	
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endorsed by		<u>'</u>





ADULT NURSING CARE PLAN

Mr.SOMASUNDARAM M

47/Malc/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V





	_ .		- 112				
Initial Date: 5 11 2	<u> </u>	Modified Date: Time:					
Reason for Modification:		Diagnosis: CAD - CUD	Diagnosis:				
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials			
NUTRITION ☐ Reep 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 Pokes disbericated Elthod DM Diet NPH had Dm diet	812 592 207			
OXYGENATION Room Air Nasal Cannula / High Flow O, Mask BiPAP / CPAP Ventilator	Patient will have normal O₂ saturation Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains within established limits	☐ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises ☐ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order ☐ Utilise pulse oximetry to check O₂ saturation and pulse rate ☐ If any O₂ abnormalities detected inform immediately to	M Patiat 1s on econ air	Polz			
☐ Tracheostorny ☐ Others:	acheostomy thers: Patient will indicates, either verbally or through behavior, feeling comfortable when breathing Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis	the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and	E Pt on from air	5.D.			
		Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging patient with successful coughing	pt is on room air	12C 0207			
FLUID & ELECTROLYTES	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 Takes adequate M oral finds	Pal 2			
☐ 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 F/O Chart monitored	5.00			
,			NATA Chart	12C			

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Patient 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 Pt mobilized well	Polz 5.Di
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 /	N Patient well mobilized M Self voiding	Pod of Pod of
☐ Others:	and regular elimination patterns	silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol Check for malena / constipation / urinary retention	N Pt Self voided	200 mg
SKIN INTEGRITY Maintain normal skin integr Pressure points site assessment HAPI OPI GRADES OF PRESSURE INJURY	ity Patient will maintain normal healing status Patient will discharge with intact skin integrity		M Maintains normal 8kin integrity	lsh
GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased Intermittent Assisted		☐ Maintain adequate nutrition and hydration ☐ Proper application of medications and dressing	Pt Skin is Normal E Interprity Pt skin integrity N normal	J. 93
☐ Dermatitis☐ Pressure injury / blisters site care given☐ Others:			pt skin integrity N normal	₽0 •20}

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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 vell groomed E pt good hygians Muntained N Pt well groomed	Poliz Ser
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 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 band @ E P = ID Brand Chack N P+ ID Band P	pakn
COMFORT AND SLEEP Pain Control Sleep Patterns Others:	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and adequate sleep	Provide clean calm and restful environment Provide privacy at all time Monitor pain scale / sleep pattern Provide pharmacological and non-pharmacological therapy	M — E — N	
OBSERVATION	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	M Vital signs clocked § Roended E Pt VIS Checked ? Poronded N Pt VIS Checked & Necorded	9362 5.922 2.027
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 Preychological Support E N	Pb2

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Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions	E	valuation	Sign & Initials
COMMUNICAT Verbal Non-verbal Sigh language Others:		Patient will communic with positive feedback		Introduce the care giver	E	sfeehre well communication Pt well communicated	\$ 97 \$20 \$207
SPECIAL INTE Medication Wound care Isolation Ostomy Care Blood / Blood ptransfusion Fluid tapping DVT Managem Others:	products	To manage on time	· (Double check for high alert medication Observe and report any medication read Provide proper measures of wound care Follow hospital polices and protocols of and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing blood products and fluids Monitor DVT score and continue treatments as per doctors order	isolation ensure plood or	nedictions gina, or par order Due modifation Given	682 5 Di 2007
	Signature		Name		Emp. ID	Date	Time
Endorsed by		(D)) JV	marano.	0.6	005 06/11/23	8:00





ADULT NURSING CARE PLAN

Mr.SOMASUNDARAM M

+7/Malc/MHI202379692 05/11/2023/iPH202302190

Dr.RAJESH.V





Initial Date: 6 11 23	Time: 820	Modified Date: Time:				
Reason for Modification:		Diagnosis: CAD - PND DVD				
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials		
NÜTRITION ☐ 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 Npo E	Qdfr_		
OXYGENATION ☐ Room Air ☐ Nasal Cannula / High Flow O₂ ☐ Mask ☐ BiPAP / CPAP ☐ Ventilator ☐ Tracheostomy ☐ Others:	Patient will have normal O₂ saturation Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	□ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises □ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order □ Utilise pulse oximetry to check O₂ saturation and pulse rate □ If any O₂ abnormalities detected inform immediately to the concerned physician □ Place patient with proper body alignment for maximum breathing pattern □ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis □ Note for changes in level of consciousness □ Send sputum for culture and sensitivity based on physician order □ Maintain clear airway by suctioning or encouraging patient with successful coughing	M Potiet is on Loom au E	Paten		
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 NPo E N	Post-n_		

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	S
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	Eficourage 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 Debut no bilized well	R
			N	
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement	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 sof voidry	P
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	
		Check for malena / constipation / urinary retention	N	
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE INJURY	Patient will maintain normal healing status Patient will discharge with intact skin integrity		M done	S.
GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased		Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	E :	
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N	

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 general	Poling
SAFETY	Pätient will have no life-threatening	☐ Check the identity with ID band before any	N	
☐ Check ID Hand ☐ IV care ☐ EJV CENTRAL LINE	situations	interaction with the patient Raise side rails Provide proper invasive line care	M 10 band @	ld2
☐ Side rails ☐ Others:		□ Keep bed locked and low at all time □ Educate care providers to be the patient □ Follow restrain policy (if needed)	E	
			N	
COMFORT AND SLEEP Pain Control ☐ Sleep Patterns	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and	Provide clean calm and restful environment Provide privacy at all time Monitor pain scale / sleep pattern	М	
Others:	adequate sleep	Provide pharmacological and non-pharmacological therapy	E	
OBSERVATION Vital Signs GCS Blood Sugar Others:	Patient will have normal range of vital parameters	Menitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	M Vibal Signs Clarked & Rudael E	ls/2
			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 Pesided pey delegind	Posh_
☐ 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	
			N	

Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICAT Verbal Non-verbal	rion /	Patient will communic with positive feedbac		Introduce the care giver Encourage the use of call bell Obtain interpreter if needed		M Sffert	e verbol	Poxton
Sigh language Others:				No negative speaking about the patient's or prognosis in the patient's presence	condition	E		
						N		
☐ Medication ☐ Wound care ☐ Isolation	RVENTIONS	To manage on time		Double check for high alert medication Observe and report any medication reac Provide proper measures of wound care Follow hospital polices and protocols of		M gra	of circus	y dr
☐ Ostomy Care ☐ Blood / Blcod products transfusion ☐ Fluid tapping ☐ DVT Management ☐ Others:		and explain to the patient / family Check for cross matching and typing, to ensure compatibility Practice strict asepsis while transfusing blood or blood products and fluids		E				
			Monitor DVT score and continue treatment as per doctors order		N			
	Signature		Name		Emp. ID		Date	Time
Endorsed by	•	Nac	S	. Natini	0024		6/11/27	180









Mr.SOMASUNDARAM M 47/Male/MHI202379692 05/11/2023/IPH202302190 Dr.RAJESH.V



ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 6 11/23	Time: (6.00	Modified Date: — Time: —			
Reason for Modification:	-	Diagnosis: CAD - IVD	Diagnosis: (PD) - 14D		
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 Administered pain medicultion esperate N Administeral does and asia		
OXYGENATION Room Air . Oxygen Hood Masal 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 Menitor 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 DN 02 MASL E GLUT N SRY-100Y. DN Name Amongon Will.	Di ores	
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 	E A A	Moug -	
MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment Consider the need for home assistance (e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M E On Bed fast diaih tube insity N ON hool not	May orus Olaus	





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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 Monitous interne and output N Monitonal To Sv line Antion	yas bug.
RISK OF INFECTION Prevent Infection Others:	☐ The patient will be discharged with no hospital acquired infection		M Aseptic techniques It allowed N dooptic techniques followed	Moran.
RISK OF FALL Giddiness Independent State Dependent State	☐ The patient will have safe, free from fall hospitalization		Fall crisus Freedworfons followerd N fall rysk progotion	Maria
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 No covery - suit	March 19.
DIET & NUTRITION NPO Soft Diet Semisolid Diet Solid Diet RT Feeds	Patient will have adequate nutrition with no nausea and vomiting	□ Encourage patient to consume prescribed diet □ Record amount of food consumed □ Provide high calories, high protein diet as prescribed □ Monitor patient's weight □ Administer supplemental vitamins and minerals as prescribed □ Administer parentral or TPN per protocol if dietary needs are not met through oral intake □ Report abdominal distention, large gastric residual volume or diarrhea to doctor	M E On NPO. N ON IVF LOOM PLY	Mad 5219 Yours

Patient Specifi Problems / Ne		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
CARE OF CAT DRAINS, ETC.	HETERS,	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	E On CBD output N ON CBD urme cofft	Phi:
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 emotional reaction (grieving, depression, anger) Acknowledge and accept expression of feeling of grief and hostility 	M E Nn N	oua
OBSERVATION Vital Signs GCS Blood Sugar Others:	N	Patient will have normal range of vital parameters	Monitor vital signs regularly Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient	M Vitals Steeline Encuroden occioelly N Homosponially State	4004 004
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 / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	Provide proper education regarding follow-up diet Insist on importance of hand hygiene Explore action, reactions and adherence about medical Provide clear, thorough, and understandable explanation regarding safety precautions. Explain to perform activities / skin care that recomment by concerned doctor Use the teach-back technique to determine the patient understanding regarding importance of treatment	ions Guined browledge	Mak.
ANY OTHER N	EEDS			M E N	
	Signature	Name	Emp. ID	Date	Time
Endorsed by	Nul	g. Nalini	0024	6/11/83	180





Mr.SOMASUNDARAM M

47/Malc/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V





ADULT POST-OPERATIVE NURSING CARE PLAN

Initial Date: 1/11/23	3 Time: (0;00	Modified Date: Time:		
Reason for Modification:	25 B 4	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 Administrations person E Provided Comfortable position N Provided Confortable Poston for Patent	S. S. C. C. C. C. C. C. C. C. C. C. C. C. C.
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	Patrent is on Room air E Patrent is on supom Avi N on 02 2 life	MOQ
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 NA E NA N NA	1904. 1902. 1903.
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Patient will use safety measures to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment Consider the need for home assistance (e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	patrent reobilises after obtain vonoial E Postant is on peol-fast N En Sed reef.	Nor De La La La La La La La La La La La La La

				
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE Oral Intravenous Enteral Nutrition Parenteral Nutrition	Patient will have balanced fluid and electrolytes balance	Enhance fluid intake unless restricted Check IV sites and assess if there is any complication Provide tube feedings Monitor intake and output Measure or estimate fluid losses from all sources such	M Monious interes cent context = Monatored Io	1982 1982
☐ Others:		as diaphoresis, wound drainage, and gastric losses Monitor for possible sources of fluid loss Monitor BP for orthostatic changes	Maintained Ilo	037
`` *			N every hour.	9265
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	M Asaptic reemiques	ma
,	, , ,	after patient's care Inspect wound for signs of infection, purulent drainage or discoloration Administer antibiotics as ordered	E NO signs of Infection	NOD 10135
		CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	N follomed aceptic	2165
RISK OF FALL ☐ Giddiness ☐ Independent State	☐ The patient will have safe, free from fall hospitalization	Keep bed on low position Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed	M proposervious rolloud	nia OZIO
Dependent State		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	E should be mountained	10D 0131
		Offer urinal or bedpan to the patient if needed	N Provided Safe Environment.	25565
SKIN &WOUND CARE Observe REEDA Oozing	The patient will have intact skin while staying in the hospital and on discharge	Check all drains from the operation site more frequently Provide wound care as ordered	Mintaet.	Ban,
Foul Smell	on discharge	Minimize pressure Provide adequate nutritional support Report signs of poor healing or trauma to doctor	R Skin is infact.	W2
DIET & NUTRITION	Patient will have adequate nutrition <	Encourage patient to consume prescribed diet Record amount of food consumed	on diquit diet.	Mal
Soft Diet	with no nausea and vomiting	☐ 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	Forlexated well. Patient us on	649
☐ Solid Diet ☐ RT Feeds			E Soft cliet	0139.
		needs are not met through oral intake Report abdominal distention, large gastric residual volume or diarrhea to doctor	N Eneouraged le talu acliquate nutrition.	83.62

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
CARE OF CATHETERS, DRAINS, ETC.	Patient will have patent, properly maintained catheters, drains etc	□ Check the catheters, drains etc frequently □ Observe I/O Chart □ Watch for any symptoms related to kinked or blocked tubes □ Maintain adequate cleaning and dressing	Madequerte 6 E ON CBD, wine Output is extense N Obsel ITO what	Step .
DISTURBED BODY IMAGE	☐ The patient will demonstrate initial acceptance and to newly body image	Note non verbal body language, negative attitude and self talk Note emotional reaction (grieving, depression, ange Acknowledge and accept expression of feeling of grief and hostility	M NA d E NA N NA	9 139 Jak
OBSERVATION Vital Signs GCS Blood Sugar Others:	Patient will have normal range of vital parameters	Monitor vital signs regularly Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient	M. Vitals Steeline Meurolynous only E. Monitorial vitals Rughts N. Monitorial vitals Rughts	1024 1024 1035
HEALTH EDUCATION Patient Family / Guardian Diet Disease process Infection control / PPE Medication Educate about TAC level and immunosuppressant Personal Safety Treatment Regimen Others:	Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications	Provide proper education regarding follow-up diet Insist on importance of hand hygiene Explore action, reactions and adherence about med Provide clear, thorough, and understandable explan regarding safety precautions. Explain to perform activities / skin care that recomm by concerned doctor Use the teach-back technique to determine the patic understanding regarding importance of treatment	ended Educated E	229
ANY OTHER NEEDS			М	
			E	
			N	
Signature	Name	Emp. ID	Date T	lime
Endorsed by	Q. NaOin	०० श्रप	7/11/23	1600









Patient [Mr.SOMASUNDARAM M

Name: 47/Malc/MHi202379692

UHID: 05/11/2023/IPH202302190
DOB: 07/PA/IESH.V

Dr.RAJESH.V

Institute
Every heart best counts

MHI/NUR/2022/112

Medway

ADULT POST-OPERATIVE NURSING CARE PLAN

DOA:

Consultan .

Initial Date: 8 11 6	13 Time: &- 00	Modified Date: Time:		
Reason for Modification:		Diagnosis: CAD _ TV D		
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	M Provide Combision For ton	and c
OXYGENATION ☐ Hoom Air	Patient will have no shortness or difficulty of breathing	□ Non-Pharmacological therapy □ Provide well ventilated environment	M Pt is on Room	Marie Salar
Oxygen Hood Nasal Cannula Nebulizer Ventilator Others:	or dimedity or broading	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	Fortint 18 on Poom Total 18 on roomain	A. Post
ANXIETY Increased Pulse Rate	Patient will cope properly with his illness and react positively to his	Explain all procedures to patient or family member in simple language they understand	м	
Anxious Look	surroundings	Encourage and support patient while increasing anxiety level Help patient to cope with outcomes of surgery	E	
		Keep patient in comfortable position in bed to enhance sleep	N	
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy	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	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,	M Provade Sato	25-40.
Others:			Entint tohil Tol and	
	adaptive devices to increase mobility	localized swelling, a rise in temperature)	Jupe 4000 mobilizon	MAR

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
FLUID & ELECTROLYTE 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 Maintained	00 to
☐ 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 Chart monitoral	-
			N'I lo Chaoit monitores	1000
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	M Surgical gite	034
		after patient's care ☐ Inspect wound for signs of infection, purulent drainage or discoloration ☐ Administer antibiotics as ordered	E. Mo apoplic	
		CVC dressing changing every 24 hours and surgical site dressing to changed by surgeons	n use aseptie fechnique	MOST
RISK OF FALL Giddiness Independent State	The patient will have safe, free from fall hospitalization	Keep bed on low position Use side rails (bed, cribs, and stretcher) and safety straps during mobilizing the patient out of bed	M Chimomont	8
☐ Dependent State		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	E'	
		Offer urinal or bedpan to the patient if needed	N _	
SKIN &WOUND CARE Observe REEDA Oozing	The patient will have intact skin while staying in the hospital and on discharge	Check all drains from the operation site more frequently Provide wound care as ordered	M Jurglical Sito	STO
☐ Foul Smell	·	☐ Minimize pressure ☐ Provide adequate nutritional support ☐ Report signs of poor healing or trauma to doctor	E No oozing	<u> </u>
DIET & NUTRITION	Patient will have adequate nutrition	Encourage patient to consume prescribed diet	N NO 00 zung Encouragie to tate	18/ S/
☐ NPO ☐ Soft Diet ☐ Semisolid Diet	with no hausea and vorniting	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	M adoquate nutrition	
l ∐Selfd Diét □ RT Feeds	RT Feeds		JOM dut	4
		needs are not met through oral intake Report abdominal distention, large gastric residual volume or diarrhea to doctor	n Pt had DM diet	Maker



	Patient Specifi Problems / Ne		Measurable Goals		Nursing interventions		Evaluation	A	Sign & T
	CARE OF CAT DRAINS, ETC.		Patient will have patent, pi maintained catheters, drai	ins etc	Check the catheters, drains etc frequently Observe I/O Chart Watch for any symptoms related to kinked blocked tubes Maintain adequate cleaning and dressing		M Maintained MIlochaeu	Chart harf	Agric.
	DISTURBED B	ODY IMAGE	☐ The patient will demonstrationitial acceptance and to report body image	newly	 □ Note non verbal body language, negative and self talk □ Note emotional reaction (grieving, depression of feach of grief and hostility 	sion, anger)	M -		
*	OBSERVATION Vital Signs GCS Blood Sugar Others:	N s	Patient will have normal ra of vital parameters	ange ೧	Monitor vital signs regularly Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient		M Mondon	vide)	Solto Alla Watar
	HEALTH EDUCATION Patient / Family / Guardian / Domestic Partner / Care-giver / others will gain adequate knowledge regarding treatment modalities and life style modifications Heducate about TAC level and immunosuppressant Personal Safety Treatment Regimen		giver /	Provide proper education regarding follow Insist on importance of hand hygiene Explore action, reactions and adherence a Provide clear, thorough, and understandal regarding safety precautions. Explain to perform activities / skin care that by concerned doctor Use the teach-back technique to determin understanding regarding importance of tree	about medication ble explanations at recommended at the patient's	M Provide	to a later 200 stay Foliables health	5 200	
	Others:	EEDS					oducati oducati n	on	Of Ja
	Endorsed by	Signature	3	palin	· .	Emp. ID		Date 8 11 \$3	Time





ADULT NURSING CARE PLAN

Pat Mr.SOMASUNDARAM M

Nai 47/Male/MH1202379692

H 05/11/2023/IPH202302190

Dr.RAJESH.V



Time: 8 - 0 0	Modified Date: Time:			
	Diagnosis: CAD CD VD			
Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials	
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 normal E p+ Nomed diet NPt had DH diet	Postn 8000	
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	coughing exercise / Spirometry exercises Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order	•	Postn	
or through behavior, feeling comfortable when breathing	 ☐ 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 	N Pt Is on room	See -	
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 p4 terkers archeypk	+36m	
	Measurable Goals 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 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 Patient will have balanced fluid and electrolytes balance	Patient will have adequate nutrition with no nausea and vomiting	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 Patient will have normal O, saturation Patient will have normal O, saturation Patient will no nausea and vomiting Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs Patient Repair will normal limits No other respiratory abnormatities Patient respiratory abnormatities Patient respiratory abnormatities Patient respiratory abnormatities Utilise pulse oximetry to check O, saturation and pulse rate If any O, abnormalities detected inform immediately to the concerned physician Place patient with proper body alignment for maximum breathing pattern Patient will indicates, either verbally Patient will indicates, either verbally Patient will indicates, either verbally Patient will necessary Patient will pattern to a pattern t	

. Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign &
MOBILITY	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	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 Patient mobliged freely E p+ Mobilized N PE 40001 M MObilized.	folin Son
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement Orination 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 E P+ self voidity Normal Flimination Pattorn	Astra Services
SKIN-INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI	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 Sugical site Sugical site por no openying Sugrau seto Maintain normal N ckin integrity	Ash Data

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	MPt cell graned E pt well growned NPt 4000 moderne	Polm & Sor
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 band (3) E 510 Banol (P) NJD Bard Present	sodn West
COMFORT AND SLEEP Pain Control Sleep Patterns Others:	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and adequate sleep	Provide clean calm and restful environment Provide privacy at all time Monitor pain scale / sleep pattern Provide pharmacological and non-pharmacological therapy	M E N	· _
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	☐ Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient Determine and treat the underlying cause of altered LOC Hegular blood sugar monitoring as per doctors order	M vital signs clocked E Recorded E vital signs cholu record N vitals checkeds, recorded	Mary Mary
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 prylological Support E provided prylological Support Support	2

Patient Specific Problems / Needs		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICATION Verbal Non-verbal Sigh language Others:		Patient will communicate effectively with positive feedback		☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed		M Effection	vabal unication	Pobla
				No negative speaking about the patient's or prognosis in the patient's presence	condition	Ept effe	Harry Communicia	Da
						n Pt 408 Con		May
SPECIAL INTERVENTIONS Medication Wound care Isolation Ostomy Care Blood / Blcod products transfusion Fluid tapping DVT Management Others:		To manage on time		Double check for high alert medication Observe and report any medication reaction Provide proper measures of wound care Follow hospital polices and protocols of isolation		medicati M as pour	chart	Post Fi
				and explain to the patient / family Check for cross matching and typing, to e compatibility Practice strict asepsis while transfusing b blood products and fluids		EPT Lleol	icition give cheest	Don
				Monitor DVT score and continue treatmer as per doctors order	nt	n Due doug are		
	Signature		Name		Emp. ID		Date	Time
Endorsed by		Dus		S-Nalini	00 24	+	9/11/83	16:00

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ADULT NURSING CARE PLAN

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DOB:

DOA:

Patie MT.SOMASUNDARAM M ------------

47/Male/MHI202379692 Name

05/11/2023/IPH202302190

Dr.RAJESH.V

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Initial Date: 10 [11] 23	Time: 🖔 , 🕫	Modified Date: Time:					
Reason for Modification:		Diagnosis: CAD_DWD					
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 Pt had on dict	Lvo			
			N				
OXYGENATION Poom Air Nasal Cannula / High Flow O, Mask BiPAP / CPAP Ventilator	☐ Patient will have normal O₂ saturation☐ Patient ABG levels will return to and remain within normal limits☐ No other respiratory abnormalities☐ Patient respiratory rate will remains within established limits	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 ploon noom	Dis			
☐ Tracheostomy ☐ Others:	□ Patient will indicates, either verbally or through behavior, feeling comfortable when breathing □ 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 Opal 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 Monitored Du cuelt	Бы			
☐ 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	·			
			N				

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Metbile / Immobile Walk with assistance Physiotherapy Others:	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Patient will use safety measures	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment Consider the need for home assistance	M Pf co ell mobilines	Do
	to minimize potential for injury Patient will demonstrate the use of adaptive devices to increase mobility	(e.g., physical therapy, visiting nurse) Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	E	
			N	
ELIMINATION Catheter, bedpan, urinal 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 & 10.6 voicing	Do
Others:	and regular elimination patterns	silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	E	
		and follow proper protocol Check for malena / constipation / urinary retention	N	
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE	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	M Hormal Sign	БШ
INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased			E	
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N	

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE Bed-Bath Assist-Bath Self-Care CBD Care (if present)	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 Dy mont	Blue
			N	
SAFETY ☑ Check ID Hand ☐ IV care ☐ EJV	Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails	M clear In hard	Lu
CENTRAL LINE Side rails Others:		Provide proper invasive line care Keep bed locked and low at all time Educate care providers to be the patient	E	
		Follow restrain policy (if needed)	N	
COMFORT AND SLEEP Pain Control Sleep Patterns	Patient will have comfortable sleep Patient will verbalize / or through behavior about pain relief and	Provide clean calm and restful environment Provide privacy at all time Monitor pain scale / sleep pattern	Mu apposible partion	Diro
Others:	adequate sleep	Provide pharmacological and non-pharmacological therapy	E N	
OBSERVATION Vital Signs GCS Blood Sugar Others:	Tatient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality Inform doctor if there is any abnormality Monitor GCS of patient Determine and treat the underlying cause of altered LOC Regular blood sugar monitoring as per doctors order	18tell figs	Luo
			N	
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Beliefs / Values / Customs Anxiety and Copying Pattern	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness Patient will maintain normal psychological pattern	Ray 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	My provided Lyspon	Lur
☐ Identify Stressors ☐ Others:	payonological pattern	Provide empathy and reassurance	E	
			N	

Wound care ☐ Isolation ☐ Ostomy Care ☐ Blood / Blcod products transfusion ☐ Fluid tapping ☐ Provide proper measures of wound care ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or	Bu
Others: or prognosis in the patient's presence E N SPECIAL INTERVENTIONS Medication Observe and report any medication reaction Provide proper measures of wound care Isolation Ostomy Care Blood / Blood products transfusion Fluid tapping Others: or prognosis in the patient's presence E N M Creck for high alert medication Observe and report any medication reaction Provide proper measures of wound care Follow hospital polices and protocols of isolation and explain to the patient / family Check for cross matching and typing, to ensure compatibility Practice strict asepsis while transfusing blood or	
SPECIAL INTERVENTIONS Medication	- Gu
☐ Medication ☐ Observe and report any medication reaction ☐ Wound care ☐ Provide proper measures of wound care ☐ Isolation ☐ Follow hospital polices and protocols of isolation and explain to the patient / family ☐ Blood / Blcod products transfusion ☐ Check for cross matching and typing, to ensure compatibility ☐ Fluid tapping ☐ Practice strict asepsis while transfusing blood or	- Gu
☐ Blood / Blcod products transfusion ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or	ivan vaus
☐ Others: Monitor DVT score and continue treatment as per doctors order N	
Signature Name Emp. ID Date	Time
Endorsed by 8. Nalini 0084 10/11/87	3 1400





47/Male, MHI202379692 05/11/2023/iPH202302190

Dr.RAJESH.V





Every heart beat counts

Date:

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK Date: Time				5	11	b-3		
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	commands. deficit which	ment s to verbal Has no sensory th would limit or voice pain or	4	4	9
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Molst Skin is occasionally moist, requiring an extra linen change approximately once a day		ist ly dry, linen only nging at routine	4	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 yeary short distances, with or without assistance. Spends majority of each shift in bed or chair	twice a day	de room at least and inside room every two hours	4	4	A
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		tion or and frequent position without	4	4	A
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	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 refu Usually eats more servin diary product eats between	of every meal. uses a meal. a total of 4 or gs of meat and ats. Occasionally an meals. Does upplementation	_ ر	4	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,	No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. Norchair			3	3	3
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or	chair, restraints or other devices.		-	TOTAL SCORE	22	23	23
	agitation leads to almost constant friction	slides down		Init	ial & Emp. No. of Staff Nurse:	post	Pr	
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	Init	ial & Emp. No. Sr. Staff Nurse:	W.	(10)	100





47/Male/MHI202379692 05/11/2023/JPH202302190

Dr.RAJESH.V





Every heart beat counts

(A Unit of United Al	liance Healthcare Pvt Ltd)		TOP WILL BUT AND BOTH LINES LINES AND ASSESSMENT ASSESSMENT	<u>:</u>	raeid ii			TA =
	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RIS	SK Date:	₽	IJ ₹	23
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	Resp comma deficit	ands. Has no sensory which would limit o feel or voice pain or	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	Skin is	ely Moist usually dry, linen only is changing at routine is	4		
ACTIVITY degree of physical activity	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	outside room at least day and inside room once every two hours 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	Makes	Imitation major and frequent es in position without nce	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	2: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 pi eats be	ellent nost of every meal. refuses a meal. reats a total of 4 or servings of meat and roducts. Occasionally etween meals. Does uire supplementation	3		
FRICTION	Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	strength to lift up completely during move. Maintains good position in bed			3		
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair			TOTAL SCORE	22		
	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:	0H2		
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		





47/Malc/MHJ202379692 05/11/2023/PH202302190

Dr.RAJESH.V





Every heart beat counts

Date: 11/23 6/11 7/1/22

	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISK Time	6100	20,00	8100
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort		3	3
MOISTURE degree to which skin is exposed to moisture	1. Censtantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Molst Skin is usually dry, linen only requires changing at routine intervals	B	2	2
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	1	1	1
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance		2	2
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate 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	1	2	2
FRICTION & SHEAR	1. Problem Bequires 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	y and has sufficient muscle Maintains good position in bed TOTAL SCORE Initial & Emp. No. of Staff Nurse:		1 10	2 12 Mei
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:	سوها	24	Nas





Patient Mr.SOMASUNDARAM M
Name: -7/Malc/MH1202379692
UHID: 05/11/2023/IPH202302190
DOB: Dr.RAJESH.V



Every heart beat counts

Date: 7 / 1/20 7 17 0111.

BRADEN SCALE FOR PREDICTING PRESSURE INJUNTALISK

			10/2/11/2000		104	20.00	<u>1.0.n</u>
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	à	2	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 Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	2	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 least twice a day and inside room at least once every two hours during waking hours	2	2	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	Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	2	3	3
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3:Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	2	3	2
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	slides to some extent against sheets,	3. No Apparent Problem Moves in bed and in chair independent strength to lift up completely during move. Nor chair		2	Q	2
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down		TOTAL SCORE Initial & Emp. No. of Staff Nurse:	12	14	16
Score	Interpretation: Minimal Risk: 23 - 19; At Risk /	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; H	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	الاصر عالم	185 185 24	lea 2





Patient Details (Affix Label here)

Name: My . Som as undowang

DOB: 47/1M 202379692

DOA: \$1123 202302190 Consultant: D.R.



Every heart beat counts
Date: 8 11 2

	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Date:		[]]	2_3
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	
MOISTURE degree to which skin is exposed to moisture	1.Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Oceasionally 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		_C	
ACTIVITY degree of physical activity	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	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		W.	
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Stight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance		3	
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally, eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3 Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	3	3	
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum	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	No Apparent Problem Moves in bed and in chair independently strength to lift up completely during move. Nor chair		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:	超		
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	24	ļ

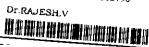




Patient Mr.SOMASUNDARAM M Name: 47/Male/MHI202379692

UHID: 05/11/2023/(PH202302190 DOB:

DOA:





Every heart beat counts

	DRADEN 3	CALE FOR PREDICTI	10 PHESSONE MOON	Time:	M	F	LN
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 discomfet 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	H	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 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 day	4. Barely 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 withous 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	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		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 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		3	3
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,	Afrength to lift up completely during move. Maintains good position in s. or chair s. air TOTAL SC		3	3	3
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or	chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally			22	22	22
Score	agitation leads to almost constant friction Interpretation: Minimal Risk: 23 - 19; At Risk /	slides down Mild Rísk: 18 - 15; Moderate Risk: 14 - 13; h	High Risk: 12 - 10; Severe Risk: 9 - 6	of Staff Nurse: Initial & Emp. No. of Sr. Staff Nurse:	10h	112 24	124

BRADEN SCALE FOR PREDICTING PRESSURE INJURY KISK





Patient Patient MI.SOMASUNDARAM M

Name: +7/Male/MH1202379692 UHID:

05/11/2023/PH202302190 DOB:

Dr.RAJESH.V

DOA:

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

Consulta William Willi



Every h	eart b	eat c	ounts
Data	10	A	50

				- + to - time.	{ - (<u></u>	(A
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	Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	2		
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 a must be changed at least once a shift	3-Occasionally Molst Skir) is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	3		
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3-Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	3		
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3.81tght Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance			
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	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. N or chair		3 19		
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:	24		





47/Male/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V



MHI/NUR/2022/052



PAI	N RI	E-ASSESSMENT	& МС	NITORING	CHART IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	Y ''' Every heart	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.	Senior Staff Initial & Emp. No.
Sulva li-	0/10	No pain	_	_		Polin	6 003
! 5.∞	0/10	No pain		*		5.9	
.]9.∞	0/10	No pain				25	100°0°0°0°0°0°0°0°0°0°0°0°0°0°0°0°0°0°0
23,60	0/10	No pain				DC 0907	Of S
6 11 bz 3.00	0)(0	No Pain	•	_		199 0	D2004
7,00	olio	No pain		<u> </u>		D(0207	(18°2)
							. "
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·									
Time Carre (dull, ach	Pain Character y, sharp, stabbing, shooting, ng, referred / radiant pain)	Duration	Location / Site		Staff Initi & Emp. N	initial &			
			P/	AIN SCALES					
PIPPS (28 weeks to ≤ 38 weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to severe	e comfort me		on					
CRIES (38 weeks - 2 months)	The CRIES scale is used further pain assessment							· 4 ,	
FLACC Scale (2 months - 7 years)	0: Relaxed & comfortable	e, 1-3: Mild di	iscomfort, 4-6: Mode	erate discomfort, 7-10: Se	vere discomfort / pa	ain / both			
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)	O 2 No Hurts Hurt Little Bit	4 Hurts Little More	6 Hurts Even More	8 10 Hurts Whole Lot Worst	Numeri 0 1	cal Rating 2 3	Scale (age	 	
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)		Absence of m ITILATION (li ubated patier elaxed, 1 - Te	novements or normal ntubated patlents): (nts): 0 - Talking on no ense, Rigid, 2 - Very Te	position, 1 - Protection, 2 -) - Tolerating Ventilator or M rmal tone or no sound, 1 - ense, Rigid	lovement , 1 - Cough	ning but tolera		g ventilator (or)	
Non-pharmacological Interventions	Distraction: A - Relaxation Cutaneous Stimulation a Thermal Theraples (no lo Transcutaneous electrica	nd massage: nger than 15	: E - Positioning; F - F to 20 minutes): G - C	ubbing / Massage the skin old application; H - Hot app	olication; I - Shortway		- Individual Cou	nseling; L - Far	nily counseling
									

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47/Male/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V



MHI/NUR/2022/052



Every hear't 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.	Senior Staff Initial & Emp. No.
6/11/23 14:00		Acley pain	Losec	STEROLUM	Mon pharmoundagical cinterention. gipp.	Moura.	Nue-
16.00°		Admy pain	·	(stosneem	intervention given . Intervention given	Moria	Nac
18,00	Yro	Dul pain	Losec	btesnum	Non pheamaurupgical cintervention given	oug	N-024
J 0•∞	1/10		<10 Olas	back	Non pharmacological Managamont dow.	Clarin och	Nac 024
97.00	Slo	,	10-15 Osse	Otermena	pharmacological management dow.	Pour of the	Naa 024
20.00 Hi	% o	doll-pain	(15 Obse	Otaraum	New phase majorage real management stone.	Olato 44	Nac- 024
03:00		_	Υ .		-	Lav.	Nac- 024
0A:00	-	-		-		clair of	Nac
0 6, 00	1/9	dull pain	10 de	drain certa.	harnocological management don.	Abris 14	Nac

Date & Time	Paln Score	(dull, achy,	ain Character sharp, stabbing, shooting, , referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
8:00	Ųο	- Di	ul pain.	Klosec	Gresnum	griver griver	รูบ	024
10:00	1/10	. Ac	ly pein	(losee	Greenum		Mar	Nas 024
1200	1/10	, C	ull Pour	5-10 Bus	Suggal		LOVE	Nach only
400	2/10	A	chy Pauri	5.scv	Stranu	Non - Negamordouscal	10P	Nca-
		4		 	PA	AIN SCALES		
(28 week	PIPPS cs to < 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	de comfort me			,	
(38 we	CRIES eks - 2 m	onths)				of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, jesic administration is indicated for a score of 6 or higher.	ı	
	ACC Sca		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	60 Hurts Little More	6 Hurts Even More	Numerical Rating Scale (age model) 8 10 Hurts Worst None Numerical Rating Scale (age model) 0 1 2 3 4 5 6 Moderate	7 8	9 10 .
Observa	ical care F ition Tool ator / com	(CPOT)	COMPLIANCE WITH VEI	Absence of m NTILATION (II ubated patier Relaxed, 1 - Te	iovements 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 v rmal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing nse, Rigid	entilator (or)	
	harmacol terventior		Cutaneous Stimulation a Thermal Theraples (no lo	ind massage: onger than 15	E - Positioning; F - R to 20 minutes): G - Co	- Music; D - Physical and mental exercisers ubbing / Massage the skin old application; H - Hot application; I - Shortwave diathermy erferntial therapy Psycho-social therapy/counselling: K - Individual Counse	eling; L - Family	counseling
Pharmac	ological I	ntervention	is as per doctor's prescrip	tion				



PAIN RE-ASSESSMENT & MONITORING CHART



Mr.SOMASUNDARAM M

47/Malc/MHI202379692

05/11/2023/IPH202302190

DOE Dr.RAJESH.V

DO/ HOME HANDER HANDER

MHI/NUR/2022/052



Every heart 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.	Senior Staff Initial & Emp. No.
1600	2/10	Achy Pain	5-10 -8ccs	Steinum	Phaemologial Tulemento gunen	19P 013 c	Nue
18:00	ho	Kull Buri	5.8Us	Surgical	Non- pharmacological Intervention given	MP DIR	Nad
20.00	2/10	Dull ache	20Sec.	Lugae of Site	Non-pharmacological intervention done.	8365	Nac-
.9 2.00	1 10	Dull ache	10 Sec.	0	Pharmacological intervention done.	0264	Nac
00.00		Paltent is BI	ecfsing			Job S	Nac 024
2.00		Patient is	Steepi	%		Je C	pas
A.00		Patient is	Bleefi	B		Doing	Nac 024
6.00	1/10	Dull ache	15 Sece.	Bugical Lite	Non-pharmacological interentem done.	2000	Nas
					Diagnosical Dam	<u> </u>	7

Date & Time	Pain Score	(dull, achy,	ain Character sharp, stabbing, shooting, , referred / radiant pain)	Duration	Location / Site		Intervention	s		Staff Initi & Emp. N	al	enior Staff Initial & Emp. No.
lo ot	lio	•	Dull Pain	210-15°	Surgical Rito	non-pho Enterue	rmace entibn	ologic	al one	2/	fu. 1	024
12.00	Q [10	ı 	No pain									per ory
400	1/10	<u>_</u> j^	Juli Peuin									
1_	/ //			05	Surgical	, , , , , , , , , , , , , , , , , , ,	om for to	V	dition		,	N2 -
<i>ጸሴ</i>	410		hul fain	Doe.	<u> </u>	AIN SCALES		ration		11		
(28 week	PIPPS (s to <u><</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provi >12 = Moderate to sever	de comfort me		no						
(38 we	CRIES eks - 2 ma	onths)				s of gestation. A maximal sco gesic administration is indicat				4,		
	ACC Scal		0: Relaxed & comfortable	e, 1-3: Mild d	iscomfort, 4-6: Mode	erate discomfort, 7-10: Severe	e discomfort / pa	ain / both			•	
Pain	-Baker F# Rating Se ars - 12 ye	cale	O 2 No Hurts Hurts Little Bit	4 Hurts Little	6 Hurts Even More	8 10 Hurts Whole Lot Worst	Numeri 0 1	cal Rating	Scale (age	 	2 ye:	ars) 10
Observa	ical care F ition Tool ator / com	(CPOT)	COMPLIANCE WITH VE	Absence of m NTILATION (I tubated paties Relaxed, 1 - Te	novements or normal ntubated patients): 0 nts): 0 - Talking on no nse, Rigid, 2 - Very Te	position, 1 - Protection, 2 - Res) - Tolerating Ventilator or Move rmal tone or no sound, 1 - Sigh ense, Rigid	ment , 1 - Cough	ning but tolera		g ventilator (or)		
	harmacol tervention		Cutaneous Stimulation (Thermal Therapies (no I	and massage: onger than 15	: E - Positioning; F - R to 20 minutes): G - Ce	- Music; D - Physical and men ubbing / Massage the skin old application; H - Hot applica terferntial therapy Psycho-s	ition; I - Shortway		- Individual Cou	nseling; L - Fan	nily ço	unseling
Pharmac	ological I	nterventio	ns as per doctor's prescrip	otion								





Patient Details (Affix I ahel here)

Nam Mr.SOMASUNDARAM M

UHID 47/Malc/MHI202379692

DOB: 05/11/2023/1PH202302190

Dr.RAJESH.V

MHI/NUR/2022/052



ery heart beat counts

PAIN RE-ASSESSMENT & MONITORING CHART

					O 1741	•		
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.	
22.00	710	Pull Pain	ong off	Stornum	Provide phasmoco logical Scupposul	MRy	Nua 024	
9 lub3 2-00	Vio	Dull pain	ong off	sternum	provide Phasmo cological suppost	MP	Naa- 024	
6-00	0/10	NO Pain	-	-	•	De la compas	Nae 024	
lo. ³⁰	مال	No pain	~	_		pstm	Nac 024	
mao	olo	No pain	_	_		Ser	Naca	
1800	010	Nopain	-			Son	Nac ozy	
9200	oleo	NO Pain	-	-	~	MI	Nae - 024	
5-00 0445	Oho	No Pain	 -	^		AR	Na 0024	
6.00	of to		-	-		LI COM	New	

Date & Time	Pain Score	(dull, achy	Pain Chara , sharp, stab g, referred / ra	bing, shooting,	Duration	Location / Site	İr	ntervent	ions					Staff Initia & Emp. No	" In	ior Sta itial & np. No
000	0/10) - (% o	pain	-								4	(by	Po	224
į				. •		:		\ /				•	,		!	
	PIPPS			= Minimal to no			N SCALES						<u></u>			
(28 week:	s to < 38 CRIES eks - 2 mo		>12 = Mo	derate to sever	e pain - Pharr for infants >	nocological intervention than or = 38 weeks	of gestation. A maximal score sic administration is indicated					S score i	s > 4,			
	ACC Scal		0: Relaxed	d & comfortable	e, 1-3: Mild d	Iscomfort, 4-6: Moder	ate discomfort, 7-10: Severe d	liscomfort	t / pain	/ both						
				(ão)	(66)	(a) (d)	400	Nun	nerica	l Ratin	ng S	cale (aç	je mo	re than 1	2 year	s) .
Pain	Baker FA Rating So Irs - 12 ye	cale	(%) 0	2 Hurts Little Bit	4 Hurts Little	6 Hurts	8 10	• •	 · · · · 1 :	 2 3 ↑		5	- - 6 	7 8	9	 10
Observat	cal care P tion Tool tor / coma	(CPOT)	BODY MO COMPLIA VOCALIZA MUSCLE	XPRESSION: 0 VEMENTS: 0 - NCE WITH VEI ATION (non-int TENSION: 0 - F	Absence of m NTILATION (I Subated paties Relaxed, 1 - Te	eutral, 1 - Tense, 2 - Grin novements or normal pontubated patients): 0 -	sition, 1 - Protection, 2 - Restle Tolerating Ventilator or Movern nal tone or no sound, 1 - Sighin se, Rigid	ent , 1 - Co	Agitation	g but tole	erating ut, so	Modera g, 2 - Fig bbing			evere	
		ogical	Distractio	n: A - Relaxation	n-conducive e	environment; B - TV; C -	Music; D - Physical and mental bbing / Massage the skin	l exerciser	s	. -		•			-	





47/Male/MHJ202379692 05/11/2023/JPH202302190

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

	Date	dula	6/11/23					
<u>i </u>	Time		6.00					
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	P	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)	О	0					
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	O	Q					
5	Entire leg swollen (Assess for both legs)	0	b				 	
6	Localized tenderness along the deep venous system (Assess for both legs)	0	o					
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	ю	b					
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0					
9	Previously documented DVT (Assess for both legs)	0	0					
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	Q					
	FINAL SCORE	Ø	0					
Low R	isk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	صمر	Low					
	DVT prophylaxis started	☐ Yes	□ Yes □ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	□ Ye : □ No
	Signature & Emp. No. of RN	02/2	2001 2001					
	Signature & Emp. No. of Sr. RN	(19)	®,√					
		OOO.	100			-		



47/Male/MHI202379692 05/11/2023/IPH202302190

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

		6/11/23		811 23	91123	DIE		
	Time	16.00	100	6.00	600	6.00		
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	0	0	Ó	0		
2	Bedridden recently >3 days or major surgery within four weeks	+1	41	+1	+1	41		
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	D	0	D	0	0		
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	D	0	Ð	0	0		
5	Entire leg swollen (Assess for both legs)	D	0	0	0	0		
6	Localized tenderness along the deep venous system (Assess for both legs)	b	0	0	0	O		
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	b	o	0	0	O		
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	b	0	0	0	0		
9	Previously documented DVT (Assess for both legs)	D	0	0	0	0		
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	D	0	0	0	Ð		
	FINAL SCORE	+1	41	+1	-+1	+1	_	
Low R	lisk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	MOD.	Mod	New	M09	1400		
	DVT prophylaxis started	☐ Yes ☐ No	✓ Yes	☑ Yes □ No	☐Yes ☐No	(□XISS □No	☐ Yes ☐ No	☐ Yes ☐ No
	Signature & Emp. No. of RN	Mouch	X	8565	10	E S		
	Signature & Emp. No. of Sr. RN	بالمول	المحال	سدوا	مارا	Na		
				-	one	12 July 1		



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NABH NABH

MI.SOMASUNDARAM M

47/Malc/MHI202379692

05/11/2023/IPH202302190

Dr.RAJESH.V





MODIFIED MORSE FALL RISK ASSESSMENT CHART

Time No Yes No Yes No	Silbs 11-20 25 0	197 * -	٥	811/2 2 50	0	0			
No Yes No Yes		a	0	• /	0	•			
Yes No Yes	25	a	0	• /	0	_		_	
No Yes		25	1 -		-	U	0	0	0
Yes	0		25	25	25	25	25	25	25
		0	0	0	<u> </u>	0	0	0	0
Na	_15	15	15/	15	15	15	15	15	15
NO	0	ug/	9	9	0	0	0	0	0
Yes	20	20	20	20	20	20	20	20	20
			_						
	0	6	0	9	0	0	0	0	0
	15	15	15	15	15	15	15	15	15
	30	30	30	30	30	30	30	30	30
		_			_				İ
	<u></u>	0	S	0	0	0	0	0	0
	10	10	10	10	10	10	10	10	10
	20	20	20	20	20	20	20	20	20
	6	0	.0/	0	0	0	0	0	0
	15	15	15	15	15	15	15	15	15
No	æ	0	0	0	_ 0	0	0	0	0
Yes	15	t5⁄	15	15	15	15	15	15	15
	30	30	3,10	30					
			,		_				_
			✓						
	axh	-5Å	2007	o Ha					
	(V)	(PO21	(C)/s	المقالة					
		15 30 0 10 20 15 No 8 Yes 15	15 15 30 30 0 0 10 10 20 20 0 0 15 15 No 0 0 Yes 15 t5	15 15 15 30 30 30 0 0 0 10 10 10 20 20 20 0 0 0 15 15 15 No 0 0 Yes 15 15 15	15 15 15 15 30 30 30 30 30 30 30 30 30 30 30 30 30	15 15 15 15 15 15 30 30 30 30 30 30 30 30 30 30 30 30 30	15 15 15 15 15 15 15 15 15 30 30 30 30 30 30 30 30 30 30 30 30 30	15 15 15 15 15 15 15 15 15 15 30 30 30 30 30 30 30 30 30 30 30 30 30	15 15 15 15 15 15 15 15 15 15 15 15 15 1

INTERVENTIONS	Date	Jul 22	5/11)2.	5/11/20	11123					
Tick as per the Risk Score	Time	11-90	11. 23	20.00	4.8					<u> </u>
		<u> </u>	ΙΦΦ	auru	 '6		<u> </u>	├	_	
Low Risk Interventions (0 - 24)			·	~						
Familiarize the patient with the immediate surround					//			 	 	-
Remind the patient to use call bell before getting ou Keep the two side rails in the raised position at all t		_			-		ļ	├	-	
all patients regardless of age	imes ior		/		/					1
Keep the call bell, bedside table, water, glasses w	ithin the	 	. /		 			 		
patient's easy reach										
Remove excess equipment or furniture to make	a clear				/			 -	1	
path										
Keep the patient's bed in the low position at all times	sexcept		. /		U	* **				
during procedure	•						1	1	Ì	•
Teach fall-prevention techniques, such as sitting	up for a									-
moment before rising from the bed					/			l		L.
Bed wheels should be locked					/					
Encourage family participation in the patient's care										
Ensure that floor of the bathroom is dry and not slipp										
Review medications for potential side effects the	hat can	7	/		1//				[ļ
promote falls					<u> </u>			<u> </u>	ļ	
Use safety belts during movement in wheelchair					<i></i>			ļ	ļ	
The patients are not ambulated by themselves. The	ey are to	/	/							ļ
be ambulated only with assistance				<i>'</i>						
Medium risk interventions (25 - 44)										
Apply all the low risk interventions				<i>-</i>	4			ļ	 	
Tie yellow fall risk tag in the bed and Wheel chair / St								<u> </u>	}	
Make sure that proper transfer precautions are in										
for heavy or debilitated patients in a bed or wheel on a toilet seat	chair or				′			}		1
Use restraints and bed monitors as ordered by the	doctor				 /			 -	 	
Allow the patient to ambulate only with assistance	aoctoi	-	-		1			 	 	
Consider peak effects of the medications that effects	cts level	 			 		_	 		
of consciousness, gait and elimination when p						ı	ļ			ļ
patient's care	9	′		~				1		
Do not leave patients unattended in diagno	ostic or							<u> </u>	l	
treatment areas							1			
Accompany the patient while going to bathroom		7			7.]	
Advice the patient to use grab bars near the toilet, t	oathtub,	/		_						
and shower								<u> </u>		
Make sure the family and other visitors underst	and the]						1	1)
restrictions mentioned above										
High-risk interventions (45 or above)							_	\vdash	Ť T	
Apply all the low and medium risk interventions	hor	-						 -	-	
Tie red fall risk tag in the bed, wheel chair and stretc Locate the high-risk patients in a room close to the		 -			-	-		├─	-	
station	mulaes				<u> </u>			<u>L</u> _		
Answer these patients call bells as quickly as possil	ble									
Provide a commode at bedside (if appropriate)								<u></u>		
Urinal/bedpan should be within easy reach (if appro							<u> </u>	<u> </u>	ļ	<u> </u>
Encourage family members or other visitors to s	tay with							[
them		<u> </u>		<u> </u>	 - -		1	 		-
If appropriate, consider using protection devices	s: safety	1								
belts		, 0	a\	nt.	+			<u> </u>		
Signature & Emp. No.	of RN	Books.	<i>5</i> 92/	620T	8%,					
Signature & Emp. No. of S	Sr. RN	آھي	(A)	(B)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \					
- · · · · · · · · · · · · · · · · · · ·										

Medway Hospitals

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



Mr.SOMASUNDARAM M

47/Male/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V





MHI/NUR/2022/046

MODIFIED MORSE FALL RISK ASSESSMENT CHART

		I A I	. *	_~~	1.10	1		ſ	1	· · · · · · ·
Variables	Date	6/11/23	6/11/23	1/11/2	7/11/22	4/11/25	8/11/8	8/11/2	8/11/23	9/11/20
variables	Time	16:00	10.00	2:00	14.00	21.00	8-00	Ulo:	20.00	8.5
History of falling	No	10	9	ø	,8 1	6	(e)	•	سف	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	18	15	18	45	(5)	15	1150	18
Intravenous Therapy /	No	0	0	0	O	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	20	30	20	20	20	(20)	20	t20	20
AMBULATORY AID					1					
None / Bed Rest / Nurse Assist		0	,0	,0	0	LO	(0)	�/	سما	9
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT					1				ļ _	
Normal / Bed Rest / Wheel Chair		0	J8		9/	10	<u>(0)</u>	Q/	10	_O
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	,8	0	0/	LO	6	o/	w	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	1,5	15	15/	15	15	15/	1150	15
Total Score		65	50	50	50	50	Sto	So	50	8
Low Risk (0 - 24)										
Medium Risk (25 - 44)		,								
High Risk (45 or above)		1			1	N	~		~	
Signature & Emp. No. of RN		Doug	Jan 24	000	NO P	8565	8	X	Was	axo
Signature & Emp. No. of Sr. RN		NOS.	OS LY	1954	1281	Neg	18824	3/2	Tag A	NO X
		70.	24: Low	Risk; 2	5 - 44: N	1edium	Risk; 45	or abo	ve: High	Risk

	Doto	11.2	1,123	dule3	t/11/92	1,123	21.10	ــا ړ	ام	, ,
INTERVENTIONS	Date	blil23	19/1/2	160.	14,	1/11/1	8/11 43	79/11	8111	19/19
Tick as per the Risk Score	Time	16:00	2000	B-00	3A00	20.00	8-00	10	20	حوري ا
Low Risk Interventions (0 - 24)			/							1
Familiarize the patient with the immediate surround	ings								<u> </u>	
Remind the patient to use call bell before getting ou	t of bed								<u></u>	
Keep the two side rails in the raised position at all t	imes for								,	- /
all patients regardless of age			/							
Keep the call bell, bedside table, water, glasses w	ithin the		/						-	
patient's easy reach			<u> </u>							
Remove excess equipment or furniture to make	a clear	1	/						5	
path Keep the patient's bed in the low position at all times	eaveent	<u> </u>	ļ * 							
during procedure	s except		/						-	
Teach fall-prevention techniques, such as sitting	up for a								/	
moment before rising from the bed	-p .c. c		/						5	
Bed wheels should be locked										
Encourage family participation in the patient's care		Ì				,				
Ensure that floor of the bathroom is dry and not slip	pery		7						<u> </u>	
Review medications for potential side effects to	hat can		/							
promote falls			/						-7	
Use safety belts during movement in wheelchair									<u> </u>	
The patients are not ambulated by themselves. The	ey are to								/	
be ambulated only with assistance			/						$\overline{}$	
Medium risk interventions (25 - 44)			/							
Apply all the low risk interventions									9	
Tie yellow fall risk tag in the bed and Wheel chair / Si									<u> </u>	
Make sure that proper transfer precautions are in			/						, ,	
for heavy or debilitated patients in a bed or wheel on a toilet seat	chair or		'		ļ					
Use restraints and bed monitors as ordered by the	doctor								•	
Allow the patient to ambulate only with assistance	200101		/		<u> </u>					
Consider peak effects of the medications that effects	cts level		/						/	
of consciousness, gait and elimination when p						ĺ			<u></u>	
patient's care	J		´ 、						/	~
Do not leave patients unattended in diagno	stic or									
treatment areas			' /							
Accompany the patient while going to bathroom							_		J	
Advice the patient to use grab bars near the toilet, t	oathtub,									$\Box Z$
and shower					ļ				7	
Make sure the family and other visitors underst	and the								'	/
restrictions mentioned above										
High-risk interventions (45 or abovc)					1		~		•	,
Apply all the low and medium risk interventions	hau		//			V	•	-,_		-
Tie red fall risk tag in the bed, wheel chair and stretc			//			~	<u> </u>		7	· /-
Locate the high-risk patients in a room close to the station	nuises	v	/		1		~	/		/
Answer these patients call bells as quickly as possib	ole	NA	NA	NA	NA	NA	NA			
Provide a commode at bedside (if appropriate)	- · - · · · · ·	NP	No.	NA	NA	NA	MA	Ť	رسو	\vdash
Urinal/bedpan should be within easy reach (if appro	opriate)	NA	No	M	NA	F44	M		<u>-</u>	
Encourage family members or other visitors to s		101.			7	<u>'</u> ``				,
them		M	Ma	M		V	m	V	/	
If appropriate, consider using protection devices	: safetý	:/ -		_		V				['/]
belts		<u> </u>	W. Ko.					$\stackrel{\sim}{\longrightarrow}$		/
Signature & Emp. No.	of RN	You.	A Ak	1/2	W.	12:16	2		1 Dans	المده
Signature & Emp. No. of \$	Sr. RN	<u> 3</u>		J.	9	. 050	Les L		ر کون	79
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The way to better health
(A Unit of United Alliance Healthcare Pvt Ltd)



MI.SOMASUNDARAM M

F 47/Male/MHI202379692 D 05/11/2023/IPH202302190

Dr.RAJESH.V



MHI/NUR/2022/046



MODIFIED MORSE FALL RISK ASSESSMENT CHART

;ι

Variables	Date	V V	9/11/23	<i>(सं</i> ॥						
variables	Time	w	2006	2,00						
History of falling	No	ے ا	V0-	0 7	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	45	15 7	15	15	15	15	15	15
Intravenous Therapy /	No	0	0	رُهِ	0	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	_20	200 0	_20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	-0	•	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15 '	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		_0_	سفر	اع	0	0	0	0	0	0
Weak		10	10	10/	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	•	0	0	0	0	0	0
Overestimated or forgets limitations		15	معروله	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-	15	1.5	15	15	15	15	15	15
Total Score		50	3 6	30						
Low Risk (0 - 24)	İ	1			İ					
Medium Risk (25 - 44)				7						
High Risk (45 or above)			-	-						
		_	W.					\vdash		
Signature & Emp. No. of RN		1806V	104960	18 leb		i .		ļ		

<u> </u>			1.108	Nu.						•
INTERVENTIONS	Date	alut	9/11/2	Appr						
Tick as per the Risk Score	Time	14.0	20.00	₩ ~						
Low Risk Interventions (0 - 24)	1									
Familiarize the patient with the immediate surround	dinas			5]		
Remind the patient to use call bell before getting ou				(<u> </u>			
Keep the two side rails in the raised position at all								1		
all patients regardless of age		<u>ر</u>					<u> </u>	1.		
Keep the call bell, bedside table, water, glasses w	vithin the			-						
patient's easy reach								<u> </u>		
Remove excess equipment or furniture to make	e a clear	}	-	ー				1		
path Keep the patient's bed in the low position at all time	e oveent	4							<u> </u>	 -
during procedure	es except			′						
Teach fall-prevention techniques, such as sitting	up for a			-				i -		
moment before rising from the bed	·•· •		7	- 6				}	}	
Bed wheels should be locked			~							
Encourage family participation in the patient's care			7						1	
Ensure that floor of the bathroom is dry and not slip			-							
Review medications for potential side effects	that can									
promote falls										<u> </u>
Use safety belts during movement in wheelchair			-7	/						
The patients are not ambulated by themselves. Th	ey are to			フ						
be ambulated only with assistance			—)							
Medium risk interventions (25 - 44)		_	7	-/				†		
Apply all the low risk interventions	N			-				ļ		
Tie yellow fall risk tag in the bed and Wheel chair / S Make sure that proper transfer precautions are in		-						1	ļ	
for heavy or debilitated patients in a bed or wheel										
on a toilet seat	i Criali Oi		~ /							
Use restraints and bed monitors as ordered by the	doctor	<u>د ـــ</u>	-	\sim						
Allow the patient to ambulate only with assistance			-	つ.				<u> </u>		
Consider peak effects of the medications that effe	ects level									
of consciousness, gait and elimination when p	planning				7					
patient's care			'							
Do not leave patients unattended in diagno	ostic or									
treatment areas		<u> </u>		->						
Accompany the patient while going to bathroom		<u> </u>	•	7					ļ	<u> </u>
Advice the patient to use grab bars near the toilet,	bathtub,	_	- つ :	-					ļ	
and shower	tand tha							ļ	ļ	-
Make sure the family and other visitors underst restrictions mentioned above	tand the	-			_				ļ	
High-risk interventions (45 or above)		<u> </u>		_						
Apply all the low and medium risk interventions		<u> </u>								
Tie red fall risk tag in the bed, wheel chair and streto	cher	 								
Locate the high-risk patients in a room close to the		<u> </u>					1	1	T	
station		<u>~</u>								
Answer these patients call bells as quickly as possi	ible	\overline{C}								
Provide a commode at bedside (if appropriate)										
Urinal/bedpan should be within easy reach (if appr										
Encourage family members or other visitors to s	stay with					İ				
them	er potetr	\vdash								
If appropriate, consider using protection devices belts	s. salety]
	-4 DN	9-	214	A			<u> </u>	+		
Signature & Emp. No.		Desig	CANA,	0000						
Signature & Emp. No. of	Sr. RN	Ly.	200	للرميات						
-		a T	.0	`O'		<u> </u>	<u> </u>			







PATIENT AND FAMILY EDUCATION RECORD

Assessment To be fi	illed	by cond	cern	ed d	iscij	plines. U	lse k	cey b	elov	~				
Barriers to	Lea	rning					_	-		Plan t	o A	ddı	res	s Factors
None		Vision	/ He	arin	g lin	nitations	;			Use	of Ir	iterp	rete	r
Limited Reading Abilities		Physic	al b	arrie	rs				E	Edu	cate	fam	ily	
Religious / Cultural Factors		Langu	age	barri	ers					Sim	ple l	ang	uag	e
Congnitive Limitations - unable to		Low m	otiv	atior	ı / d	esire to	lear	n] Writ	ten l	nstı	ıctio	ns
understand and follow directions				_									·	
Completed By : Date 5 11	e	11.00	•	N	lurs	se Signa	ture	:	4	24/2				
		<u>-</u>			_				<u>~~</u>	_				
earning Record											<u> </u>			
Need		Date		/isit	1	Date	<u> </u>	√isit	sit 2 Dat		<u> </u>	/isit	: 3	Signature
		يداياك	L	P	0	6 11 23	L	P	0		L	P	0	k
Disease		,			ĺ									Doctor
Information on														
Disease / Diagnostics			P	202	1	1	۵	20	\bigvee					The state of the s
Treatment														
Medications			10	D2Ω	U		0	35)	/					Doctor / Nurse
☐ Information on Safe and							٧							A \ n ===
Effective use of medicines			D	220	را	,	Q	80	ر ا	r				Now
Information on drug / drug and					Ĭ									way
drug / food interactions	- (ļ				1			[. ' [
☐ Discharge Medications	一													
Surgical Instructions	_													Nurse
Pre - Operative Instructions			D	8	V		3	20	./					Osh
Post - Operative Instructions	\neg		<i>U</i>				-₩-	1	Γ					1
(Wound / Dressing Care)	ı													
Pain Management	\neg												Г	Nurse
Reporting of pain			0	ത	J		8	Ω.			<u> </u>		П	f. ati
Pain Management			Q	<i>2</i> 90	/		8	30 20					П	12021
Safe and effective use of medical			0	<u>رتب.</u>	μ		Ť	-					П	Doctor / Nurse
Equipment (if required)														
Name of Equipment	\dashv	,											П	
Rehabilitation Techniques	- [

Need	Date		/isit	1	Date	۱	Visit	2	Date	١	/isit	3	Signature
		L	Р	0		L	Р	0		L	P	0	
Nutritional Guidance													Dietigian
Diet Instruction for patients at Nutritional risk		-	/	_		Þ	S	6				ľ	Senior Dietiko
Diet advice for home	- 	_		~		-	-	_				\Box	Nurse
Discharge Planning													<u> </u>
Self care		\vdash					T	Т				\Box	
Follow up													
Reporting Concerns Immunizations													
Parenting education												П	
Others		T		Г			-	Г				П	
Risk Factor Reduction							† <u> </u>					H	
Smoking Cessation		Г		Г								П	Doctor
Weight Control					•								-
Exercise												П	
Hypertension												П	·
Other Risks												П	
		_											
Reports Given :													
Given Pend	di ng I	NΑ							Give	n	Pe	ndin	g NA
Discharge Summary	↓		_ '	Diet	Advice	!							_
ECG Report			_ •	CT S	Scan Re	por	t			_			
Doppler Report		CT Scan Film											
X-Ray Report		ECHO Report											
X-Ray Film			Ultrasound Report										
Compact Disk			/	Any Other Report									
Name of Attendant / Patient :					<u>.</u> .		_Sig	nat	ure :				
Name of Discharge Nurse		l					Sin	net	ure :				
Name of Discharge Nurse							SIY	ıaı	uic.				





Mr.SOMASUNDARAM M 47/Male/MHI202379692 05/11/2023/IPH202302190 Dr.RAJESH.V AND AND AND AND AND ARREST AND AND ARREST AND AND ARREST ARREST AND ARREST AND ARREST ARREST ARREST AND ARREST AR



Assessment PATIENT AND FAMILY EDUCATION RECORD To be filled by concerned disciplines. Use key below														
Barriers to	Lea	arning								Plan to	o A	ddr	es	s Factors
None		Vision	/ He	aring	j lin	itations	ı			Use	of In	iterp	rete	r
Limited Reading Abilities		Physic	al b	arrie	rs				Ľ	Edu	cate	fam	ily	
Religious / Cultural Factors		Langu	age	barri	ers					Sim	ple L	.ang	uag	e
Congnitive Limitations - unable to		Low m	otiv	ation	/ de	esire to	learr)		Writ	ten l	nstu	ctio	ns
understand and follow directions						•			·		_			
Completed By : Date bill 23 Tin	ne	8:01)	_ \	lurs	e Signa	ture	: <u>M</u>	<u>1a</u>	halau	ykr	١٠١	(1	•
Learning Record														
Need		Date	١	/isit	1	Date	Ī	/isit	2	Date	\	/isit	3	Signature
		6/11/23	L	P	0	4/11/22	L	Р	0	08 p/ p	L	Р	0	
Disease														Doctor
☐ Information on							<i>(</i> 2)	٠. ·)				Q.
Disease / Diagnostics			_				ધ્	\Im	P \	8	01,		レ	(A)
☐ Preatment							ţ		ſ	•	,		ſ	19220
Medications							J		ľ	-			Ī	Doctor / Nurse
Information on Safe and		·						\ \						MO.
Effective use of medicines							ح	Ö			ડ્ડે	9	ン	
☐ Information on drug / drug and											>			• • • • • • • • • • • • • • • • • • • •
drug / food interactions							25	\mathcal{G}	>		B	6	V	naly g
☐ Discharge Medications				1			J		\mathbb{N}		ļ		ſ	4/200
Surgical Instructions							}		,		-			Nurse
Pre - Operative Instructions	\Box						/		_		_			·
Post - Operative Instructions								φ		,	_			NOR
(Wound / Dressing Care)	\Box		S	OD.	ν.		۲.	ÞD	$oxed{Y}$		8	6	V	29
Pain Management								9	L ₄	/	δ	OĮ)	Δ	Nurse
Reporting of pain			S	ao	>		ζ	9	\checkmark		Ī	\mathfrak{A}	ν	
Pain Management			ς	OD	oxdot	-	S	9	$oldsymbol{L}$		8	6		M
Safe and effective use of medica	ıl					:								Doctor / Nurse
Equipment (if required)	_		S	6D	V	, ,					~			
Name of Equipment														

r, S-	Spo	ouse on,	e Other		P & .		8	<u>-</u>	P >		Dietician Senior Die John Nurse Doctor
r, S-	Spo	ouse on,	e Othe		$\vdash\vdash$						Senior Die Senior Die
r, S-	Spc	ousoon,			$\vdash\vdash$		8	<u> </u>			Nurse
r, S-	Spo	on,									
nst	rati	on,									Doctor
nst	rati	on,									Doctor
nst	rati	on,									Doctor
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7	_ ι		sound Other f	-							
_	_ ι			Repo	ort	nat	ure :				
١	$\overline{}$		1		<u> </u>	1	1				│ Ultrasound Report



Pa Mr.SOMASUNDARAM M Na 47/Male/MHI202379692 UI 05/11/2023/IPH202302190

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PATIENT AND FAMILY EDUCATION RECORD

Assessment To be f	illed	by cond	ern	ed di	isci	olines. L	lse k	ey b	elov	v				
Barriers to	Lea	arning								Plan t	οА	ddr	es	s Factors
None		Vision	/ He	aring	g lin	nitations	3			Use	of Ir	iterp	rete	er
Limited Reading Abilities		Physic	al ba	arrie	rs				L	Edu	cate	fam	ily	
Religious / Cultural Factors		Langua	age	barri	ers					Sim	ole L	.ang	uag	e
Congnitive Limitations - unable to		Low m	otiv	ation	/ d	esire to	learr	ı		Writ	ten I	nstu	ctio	ns
understand and follow directions														
Completed By : Date 7 11 > Tim	ne	<u>8</u> ,00		\	lurs	e Signa	ture	; A	av.	floa				
Learning Record	_							•				_		
Need		Date	\	/isit	1	Date	\	/isit	2	Date	١	/isit	3	Signature
	!	plule	L	Р	0	10/11	L	Р	0		L	Р	0	<u> </u>
Disease		7,1.17												Doctor
Information on														<u>A</u> -
Disease / Diagnostics			p	200	ے		"	D	y.					907
☐ Ireatment							Y							16 203
Medications			D	00	V									Doctor / Nurse
Information on Safe and			0				D	69						
Effective use of medicines			p	00	U		"		У					-New
Information on drug / drug and														on
drug / food interactions			p	00	<i>\</i>		0	00	V					
Discharge Medications														
Surgical Instructions														Nurse
Pre - Operative Instructions												<u> </u>	L	(4) (7)
Post - Operative Instructions	,													
(Wound / Dressing Care)													L	
Pain Management													L	Nurse
Reporting of pain			P	œ	<u></u>		\boldsymbol{v}	ďΩ	ሃ					Postn
Pain Management			P	100	<u></u>		١٠							700.
Safe and effective use of medica	1													Doctor / Nurse
Equipment (if required)		<u> </u>												
Name of Equipment														
Rehabilitation Techniques			1	i		4	1	ı	,		I		1	Ī

	 	1	Date	_\	/isit	2	Date	<u> </u>	/isit	3	Signature		
	_	L	Р	0		L	Р	0		L	Р	0	
Nutritional Guidance													Dietician
Diet Instruction for patients at Nutritional risk		b	or.	J		n	م	N		P 1	on 1	b	Senior Dielitin
Diet advice for home		1	-	-		_		F		P	<i>0</i> 0	V	Nurse
Discharge Planning													
☐ Self care								П				Г	
Follow up													
Reporting Concerns Immunizations													
Parenting education				П				П					
Others				П		Ì						Г	-
Risk Factor Reduction	_				,							П	
☐ Smoking Cessation				П				П					Doctor
☐ Weight Control				П				П			Г		
☐ Exercise				П									
Hypertension													
☐ Other Risks													
OUTCOME (O) - RD - Return Demonstruction Written Material given and explained (i		V - N	/erb	aliz	ed Und		tand						
. ,		V - \	/erb	oaliz	ed Und						L	8	00/17
. ,		V - \	/erb	oaliz	ed Und						L	8	00/17
Written Material given and explained (i Reports Given : Given Pending	f any)	V - \			<u>-</u>	ders					Per		
Written Material given and explained (i	f any)				ed Und	ders					Per		
Written Material given and explained (i Reports Given : Given Pending	f any)			Diet	<u>-</u>	ders	tano			1 1	Per		
Reports Given : Given Pending Discharge Summary	f any)		[Diet CT S	Advice	ders	tano				Per		<u> </u>
Reports Given : Given Pending Discharge Summary ECG Report	f any)		[Diet CT S	Advice Scan Re	port m	tano			——————————————————————————————————————	Per		<u> </u>
Reports Given : Given Pending Discharge Summary ECG Report Doppler Report	f any)		[Diet SCT S	Advice ican Re	port m	tance				Per		<u> </u>
Reports Given : Given Pending Discharge Summary ECG Report Doppler Report X-Ray Report	f any)			Diet CT S CT S	Advice ican Re ican Fil O Repo	eport m	tance			——————————————————————————————————————	Per		
Reports Given : Given Pending Discharge Summary ECG Report Doppler Report X-Ray Report X-Ray Film Compact Disk	f any)	1A		Diet CT S CT S	Advice ican Re ican Fil O Repo	port m Rep	tance	dine	Giver	——————————————————————————————————————		ndir	<u> </u>

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47/Malc/MHI202379692 05/11/2023/iPH202302:90

Dr.RAJESH.V





IN-HOUSE TRANSFER FORM

Dowl	A (to be filled by No.													
Part A (to be filled by Nurses) Date of Transfer: 08 1														
Date	e of Transfer: OSIM	Time: 1	. <u>Н</u> У Тга	ansferred	from: S	DIWTo:	G10.							
Dia	gnosis: CAD _	TVD, E	F _ 61,	7 .										
Vita	Vital Signs: Temp: 98.4 (°F) Pulse / HR: 166/m(beats/min) BP: 1060 (pt)mmHg) Respiration: ОН (breaths/min)													
Part	B (to be filled by Ph	ysicians)	Any Critic	al Investig	ations:									
	Check for			Trai	nsferring Docto	or	Receiving Doctor							
esp	piratory (Breath sounds)	Clear	Crepitat	tion 🔲 F	Rhonchi 🔲 O	thers:	Yes No							
Abdo	omen	Soft [Tender		oistended 0	thers:	Yes No							
Hear	t Sound	Normal [Feeble	e 🗌 Loud	d Others:_		Yes No							
CNS		Consciou	us 🗌 Or	iented	GCS Sco	re:	Yes No							
For S (if ap	Ves No													
	Present Medication (for Medication Reconciliation) S Date & Time To be continued during													
S. No.	Current Medic	Current Medication Dose Route Frequency Date & Time of last dose												
1	Syp. SUZALFA	TE	rom	0	1-1-1	08/11/23 07-30	☑Yes ☐ No							
2	NEB. LEVOLINE		0. C.2m	Jant.	QbH	92/11 bs @9.30	☑ Yes ☐ No							
3	J. PRUSE MIDE		4cmg	Po	1-1-0	08/11/d3 @ 7-30	☑Yes ☐ No							
 - -	T. SPIRANDLACT	ONE	25mg	Po	1-1-0	08/11/23 @10.00	☑ Yes □ No							
ک	T. CS-OPILET - A		TEMP	Po	0-1-0	07/11/23 @ 14.00	☑Yes ☐ No							
6	T. PARACETAMOL		bsome	PO	1-1-1	08/11 bs@ 8.30	☑ Yes ☐ No							
7	SYP CRENATEIN	Auc 204	15m	PO	0-0-1	07/11 by 00000	☑ Ýes □ No							
8	T. DILDEN - C	:I2	90 mg	120	1-0-1	08/11/23 008-30	☑ Yes □ No							
9	T. BEPLEY FOR	D.TE	1 tab	Po	1-0-0	08/11/83 08:30	☑Yes ☐ No							
10	T. ROCUVASTATIO	4	Stone	Po	0-0-1	व्योग विड क अम्व	☑ Yes ☐ No							
11	T. METAPROLOS	<u>-</u>	25mg	Po		28/11/23 @9.00								
12	T. PREGABIN		75 mg	Pb	1-0-1	08/11/23 @9.00	□ Yes □ No							
			,		_	-	☐ Yes ☐ No							
							☐ Yes ☐ No							
							☐ Yes ☐ No							

Additional Details (if any):														
						,								
Patient Condition: Stable Sick-need urgent care Others:														
	Sign.	Name	Reg. No.	Date		Time								
Transferring Doctor	8	Dr. poraveu	112236	8/11/2	2-7	11.45								
Receiving Doctor	900	Do moon hydrom	165037	2/11/0	erj (Was								
Part C (to be filled by Nurses)														
Check for		Transferring Nurse			Receiving Nurse									
Drains	Chest A	abdominal Others:	Iominal Others:			Yes No								
Respiratory	Air Way Type: Patent Tracheostomy Others: Oxygen Therapy: No Yes via: Rate: Ii/min													
NG Tube / Oral	Yes No	For Feeding Gastric Suction Fluid Restriction			Yes No									
Foley's Catheter	Yes No	☐ Yes ☐ No												
Intravenous Acc	ess Peripheral Li	Peripheral Line Central Venous Line Others:												
Pressure Injury	Yes No	Yes No If Yes, give details:												
Score	Fall Risk: 50	Fall Risk: 50 WELLS: NEWS / PEWS:												
Patient Belongin	ngs Yes No	Yes No If Yes, give details:												
Handover Detail	e l	Medication Administration Record explained: Yes No Lab & Diagnostic Reports handed over: Yes No												
Patient Attendar	nt Yes No	Yes No If No, give details:												
Additional De	tails (if any):													
	Sign.	Name	Emp. No.	Date		Time								
Transferring Nurse	D-Sheeta	D. Sheebu	0270	∞ ly	b3.	11.45								
Receiving Nurse		D. Sheebu B. Vanigi	0195	8/11/2		1 45								





47/Malc/MHI202379692 05/11/2023/1PH202302190

Dr.RAJESH.V





Inter Disciplinary Team Rounds (IDTR) Checklist

Date: Suls Time: 11.00											
Checklist	Yes No NA			Α	Action / Remarks						
MEDICAL											
Daily Consultant Visit											
Plan of care discussed		,									
Discharge Planning											
Others if any											
NURSING											
Safety Precautions Ensured											
Care of Lines and Tubes											
Infection Control Measures											
Skin Care						<u> </u>					
Response to assistance											
Others if any											
DIETICIAN											
Diet Adequate		/									
Special Request											
PHYSIOTHERAPIST						_					
Available for Assistance for Activities of Daily Living											
Others if any	7										
PATIENT CARE SERVICES											
Room Cleaning satisfactory	_										
Room Amenities Adequate											
Billing Update available					"						
Non-Availability of any service											
Spiritual Needs (if yes specify)											
Others if any											
Inter Disciplinary Team Members											
	Signature			Name	Reg. / Emp. No.	Date	Time				
Doctor				or gay	163261	5(4)25	(3,00				
Nursing Staff	los los los los los los los los los los			Pay the	007	5/11/2	12.00				
Dietician Physiotherapist	 (J	Senior Distition	<u> </u>	philu	14500				
Patient Care Service Staff	(A)			ARASH.GE	0256	B/11/29	for 100				
rations date del vice diali						1					



Mr.SOMASUNDARAM M

47/Male/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V





FAMILY COUNSELLING FORM

CONSU	LTANT-	RATESI	DIAGNOSIS- CAD-TWD			
DATE	HOSPITAL MEMBERS	FAMILY Members	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
6/11/23	MaHA MaHA Mahalan	More (asp)	Explained about patient condition, treatment process. Need at zer stearys 28-Visiting hours.	1	উত তাপ	J. Porlos
크11123	RIN PEIYANA	(wife)	Explained about severent condition of the postion to award shifting and visuing hours.	J	16° 00(5	P.L.



Mr.SOMASUNDARAM M

47/Male/MHI202379692

05/11/2023/19н202302190

Dr.RAJESH.V



MHI/PHARM/2022/029



Every heart beat counts

HOME MEDICATION FORM

Weight (kgs): 69.25 Kg

Assigned Nurse: 9/4, Suluta

Allergies, if any:

NK-DA .

Diagnosis:

CAD - LAD/ TZ DM /SHTW / MLV

The following medications brought to the hospital by the patient / attender at the time of admission have been approved for hospital use. These medications have been checked by the Clinical Pharmacist for the appropriateness, expiry date, storage condition and labeling.

Name of the Medication Pres			f the Medication Patient / Attender	Dose	Frequ -ency	Quan -tity	Batch No.	Expiry Date	Storage Conditions
To Meth	amin	ام ک	netformin	500	1-0-1	17	6208023	4/26	د25 د
T. Grlim	epride	T.6	orlimepri de	rig	1-01	3 3	O1 L111	5/25	2256
T-Pan	40	T.P	ån 40	40.9		7	KTA23 DIBAL	3/25	2250
T. Taim	etaride	7.18	imetazidine	380		Ĩ	TD N23	5/26	225°C
T- Nih	nihnwa	T-M	knowntin	2.6	<u>-</u>	+ 100+	WW(23	2/25	22.50
				0					
				:					
1	Signature		Name			Reg.	/ Emp. No.	Date	Time
Doctor	DI		Dr Valsh	nau	·	150	327	5)11/2	3 /4,750
Clinical Pharmacist	V.P-	di.	N. Padmay	porqu	5 .	02	224	5/11/23	14.30

TO WHOM IT MAY CONCERN

This is to certify that I take full responsibility for the quality and potency of the mer.ications that I have brought to the hospital. I understand that medications have to stored according to the recommendations given by the manufacturer including storage in refrigerator for the medications which requires to be stored between 2° to 8° Celsius, failure of which may affect the safety and efficacy of the medications. I assure that the above mentioned medications which I have brought from home had been stored under the temperature and storage conditions recommended by the manufacturer. Any adverse effects caused due to the medications that I have brought to the hospital, which might adversely affect my recovery due to the improper storage conditions, shall totally be my responsibility. I am aware that several medications available in the Indian and International market are spurious and can cause harm to one's health. I acknowledge that I had been explained about the above mentioned medications and its risks. I assure that, no one will hold Dr. Rela Institute and Medical Centre, Chromepet, its Doctors and its staff in any way responsible for any outcome whatsoever as result thereof.

	Signature / Thumb Impression*	Name ,	Date	Time
Patient	M. B. Julani 925	Mr Somusundharm	Shilos	116-30
Surrogate/Guardian (if applicable #)		(Write name and relationship with patient)		-
Reason for surrogate consent	Patient is unable to give consent bed	cause:		
Witness .	. hl tros	M. Suida	5/11/23	14.30
Interpreter (if applicable)				

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

MHI/HOSP/2022/110



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

Name: Mk - SOMUSUN DAFAM

Patient Details (Affix Label here)



Sex: 202379692 / Every heart beat counts

WOUND ASSESSMENT CHART

					- -			
DATE	9/11/23	us os						
SITE OF WOUND							<u> </u>	
CHEST		7						
LEG L/R								
ABDOMEN								
SACRAL REGION								
'IEEL								
OTHERS	lt hard	14 Cod						
SIZE OF THE WOUND			_					
SUPERFICIAL / DEEP IN NATURE			_			ļ		
PRESSURE Specify system used :			_					
RISK FACTORS Specify system used :	UM.	HTN	Age	Obesity				
WOUND TISSUE TYPE(S) PRESENT								
necrotic								
slough								
undermining								
granulation								
overgranulation								
epithelialisation								
other	-	9						
SURROUNDING SKIN TISSUE TYPE(S) macerated								
erythema								
oedematous								
cellulitis								
blistered								
bruising								
dry / scaling								
healthy		<u></u>						

WOUND ASSESSMENT CHART

EXUDATE AMOUNT	9/11/23	10 hiles					
none		67					
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*					=		
2 10							
SWAB SENT							
ANTIBIOTIC THERAPHY							
DI COD CI MOCCE (MIDINE ANALYSIS							
BLOOD GLUCOSE / URINE ANALYSIS							
PATIENT / CARER TO DO DRESSING							
SIGNATURE	Q. 1832	de las					
*SIGNS & SYMPTOMS OF WOUND INFECT Pytexia excess e Nicalised pain pus erythems offensive	xudate	• frag	nulation ties	ue bleeds e f epithelium	asily •	healing is si	inticipated







Every heart best counts

VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME:

Mr.SOMASUNDARAM M 47/Malc/MHI202379692

05/11/2023/iFH202302190

AGE / SEX:

Dr.RAJESH.V

IP No. / UHID No

Ward / Bed No. 5100

ANY SCORE>O SHOULD BE MONITORED IN EVERY SHIFT

				C CHOOLD BE MOIN					
DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S/N EMP No.		
blul23.				TV LINE			: 		
	14:00	RIGHT	015	TV LINE HEACHUS PATENT	FLUSHED E WS	OBSERVATION	Maha.		
	20.∞	Partial	0/5	whose potent	Alexander N		0		
1/11/23	8:00	R) CUBGAT		PATENT > HEACTY		NO SUMS OF PHIE	AND LOD		
	400		0/5	HNE PATENT &	FLUSTED		ICIP1013		
	20.00	CURMAL	015	DIFFENT Q	NO 0.97.	ON OBSERVATION	3)65		
8/11/93		ORTAL	21.	HEDLTHY	Ne 0 9/	ON OBSERVATION	1		
	20.00	DT .	015	ntont	flusho	Observation	M		
	8.00	cubital etablish	0/	Patoni Beket	PX		Post on_		
9/11/23	120	PATION	015	peeth	ghs	-	800		
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Medway Hospitals® The way to batter health (A Unit of United Alliance Healthcare Pvt Ltd)



Mr.SOMASUNDARAM M

Pi 47/Male/MHi202379692 N 05/11/2023/IPH202302190

U Dr.RAJESH.V



MHI/PHARM/2022/028



Every heart beat counts

MEDICATION ADMINISTRATION RECORD

Drug	Chart	:of	of Height (cms): <u>1580</u>							125 /c
		KNOWN MEDICINE AL	LERGIE	S (If NO	ONE is c	onfirmed	i, write NKDA i	n box 1)		•
Drug De	etails		Descri	ption of	Allergy			Doct	or's Sign:	
		MIC D A		-				Nam	e: D 'B'	ay
1 								Reg.	No. 1532	268
	ОСТО	R INSTRUCTIONS			NU	RSING S	TAFF INSTRU	CTIONS		
2. Write i 3. Sign a 4. No pre	n BLOCK nd enter escription	me when prescribing drug LETTERS, clearly and legibly MCI registration no. or apply seal should be altered / overwritten mat when writing time	2. Nurse 3. For ne follow 4. Stand Q8hrly	in-charge w prescript standard ard Timing : 06:00hrs	should ve ption, follow timings gs: Q24hrly , 14:00hrs, 2	rify drug ch w the timing : 10:00hrs, (22:00hrs or	d omissions lart on daily basis gs of doctor's presc Q12hrly: 10:00hrs, 2 09:00hrs, 14:00hrs, 2 ::00hrs, 06:00hrs, 10	2:00hrs or 0 21:00hrs, Q	6:00hrs, 18:00h 6hrly: 05:00hrs,	nrs,
		Stat / C	Once O	nly / P	remed	ication	Drugs			
Date	Time	Drug		Dose	Route		Doctor	,	Administere	d
				ļ		Sign.	Reg. No.	Sign.	Emp. No.	Time
5]112 3	1610	T-Ameanky.		224	P16	h <u>y</u>	16 5244		017)11.0
Julis	200	T- PAN		Hom	plo	Q.	150327	7.6	· (7)0)	9 - 02
Julez	χ. <i>ś</i> ′	T- ALPRAX		0.25	plo	Dr	180327	Euff	වැන	21.00
6/4/23	ص, رم	In. MORPHINE	:	5mg	Im	D	100327	gost !	20072	9.00
6/11/22	4.50	IG. PHENERGAN	<u> </u>	12.2	IM	D	150307.	Post	000	9.0
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		<u> </u>						<u> </u>		
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Date -> To be filled by Nursing Staff only. Sign and time given **REGULAR PRESCRIPTIONS** To be filled in by Doctors only Time ↓ 6/11/22 **DRUG NAME** T - ATORVA Clinical Pharmacist Medway Heart institute Dose Route Frequency Homa 0-0-1 PLS Start Date & Time
5 | 4 / 23 | 13 ! 80 Dr. Sign & Reg. No. / Seal Stop Date & Time = H3261 Sopo 200 Additional Info: **DRUG NAME** 730 T-PAM Clinical Pharmacist
Medway Heart institute Route Dose Frequency was PL 100 Start Date & Time Dr. Sign & Reg. No. / Seal 5/11/23/13:00 Ly 163m. Stop Date & Time 0 19.30 Additional Info: **DRUG NAME** مد. 🛭 T-AMLISPAN TR Route Dose Frequency 2.6ms Ph 1001 Start Date & Time Dr. Sign & Reg. No. / Seal 16-00 5/11/13/13:40 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** Dose Route Frequency Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: Area In-charge Nurse Signature:

Date	Time	Dlet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
5 n 2 3	11.00	low salt, low for om pre	- h	163268					
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		(to be entered by all the		IDENTIFIC ved in adn				rt)	
Date	Shift	(to be entered by all the					D ations prescribed in the cha Name of Nurse	Emp. No.	Initials
Date	Shift Mornin	Name of Nurse	nurses invol	ved in adn	Date Date	ng medica	ations prescribed in the cha		Initials
	Mornin	Name of Nurse	Emp. No.	ved in adn	Date I	ng medica Shift	ations prescribed in the cha		Initials
] n 22	Mornin	Name of Nurse	Emp. No.	Initials	Date I	Shift Morning	ations prescribed in the cha		Initials
Jul 22 Slub	Mornin Evenin	Name of Nurse 9 Surely U. Devilar	Emp. No.	Initials	Date I	Shift Morning Evening	ations prescribed in the cha		Initials
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Night

Morning

Evening

Night

Night

Morning

Evening

Night





Mr.SOMASUNDARAM M

47/Male/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V



MHI/PHARM/2022/028



Every heart beat counts

MEDICATION ADMINISTRATION RECORD

						•	· ·	YAKUMAN		
Druç	g Chart	: 2 of 1			Heig	ht (cms):	158 cm			<u>) · </u>
		KNOWN MEDICINE AL	LERGIE	S (if NO	ONE is c	onfirmed	, write NKDA i	n box 1)		
Drug D	etails		Descrip	ption of A	Aliergy		ı		or's Sign:	_
				_					e: DB. PRI	
٨	<i>LKDA</i>			NIL				Nam	e: DR. PRI	HABBN
							٠	Reg.	No. 1122	36
[осто	R INSTRUCTIONS					TAFF INSTRU	CTIONS		
2. Write 3. Sign a 4. No pre	in BLOCK and enter escription	me when prescribing drug LETTERS, clearly and legibly MCI registration no. or apply seal I should be altered / overwritten	2. Nurse 3. For ne follow 4. Stand	in-charge w prescrip standard ard Timing	should ve ption, follo timings gs: Q24hrly	w the timing r: 10:00hrs, C	d omissions art on daily basis is of doctor's preso 212hrly: 10:00hrs, 2: 29:00hrs, 14:00hrs, 3	2:00hrs or 0	06:00hrs, 18:00h	ırs,
5. Use 2	4-hour fo	rmat when writing time					:00hrs, 06:00hrs, 10			
·		Stat / C	Once O	nly / P	remed	ication	Drugs			
Date	Time	Drug		Dose	Route		Doctor		Administere	d
L	1,,,,,	Drug		5550	Houte	Sign.	Reg. No.	Sign.	Emp. No.	Time
6/4/23	ص الح	J. ECOSPIRIN		75mg	. 90	8	112236	Sais_	00=1A	21:00
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REGULAR PRESCRIPTIONS To be filled in by Doctors only Time \$\frac{1}{2}\text{Distance} \text{Points filled by Nursing Staff only. Sign and time given time \$\frac{1}{2}\text{Distance} \text{Time \$\frac{1}{2}\text{Distance} \text{Points filled by Nursing Staff only. Sign and time given time \$\frac{1}{2}\text{Distance} \text{Distance}	-					_							
To be filled in by Doctors only Time Time Time Time Time Time Time Time Time Time Time Time Time Time Ti		REGIII	LAR PRESCRI	PTIONS	Date →	To be	filled b	y Nurs	ing Sta	iff only.	Sign a	nd time	giveri
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Tot Para / Etaino		DRUG NAME		·· ··				-	1	I V I V			
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1			I .	Frequency		15:00	~	_	7				
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Additional Info: DRUG NAME VP CUCROLFATE SUSPENSION Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR GR. No. 17238 Additional Info: DRUG NAME NEB. / FV S D. BUTONO Dose Route Frequency NEB. / FV S D. BUTONO DRUG NAME NEB. / FV S D. BUTONO DRUG NAME NEB. / FV S D. BUTONO DRUG NAME NEB. / FV S D. BUTONO DRUG NAME NEB. / FV S D. BUTONO DRUG NAME Additional Info: DRUG NAME NEB. / FV S D. BUTONO Stop Date & Time Linip 3. Af Ib-100 Stop Date & Time Linip 3. Af Ib-100 DRUG NAME TOBUR NAME TOBUR NAME Dr. PRAVEEN JEYAKUMAR Additional Info: DRUG NAME TOBUR NAME TOBUR NAME Dr. PRAVEEN JEYAKUMAR Additional Info: DRUG NAME TOBUR NAME	-8 -	Dr. PRAVEEN J	EYAKUMAR		23:00	daus							
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Promition Prom	الراه itule	Additional Info:											
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Dr. Sign & Reg. No. / Seal Start Date & Time Ohit 2 AFF (q:3) Stop Date & Time Ohit 2 AFF (q:3)	Clir Med	Dose	Route	Frequency		دسا	8,30	\y [.] \p [*]	13790	S)	<u> </u>	- -	
Dr. PRAVEEN JEYAKUMAR Stop Date & Time DRUG NAME NEB	$\langle \langle $		· · · · · · · · · · · · · · · · · · ·	 	13:30		agin	E	(%r	B.00	ı		<u> </u>
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Dr. Sign & Reg. No. / Seal Start Date & Time Start Date & Tim	Pnarr Heart		· -		4:00	<u> </u>	Man's	12	25	200			<u> </u>
Dr. Sign & Reg. No. / Seal Start Date & Time Start Date & Tim	edway			Frequency		 >	10.00	9.30		(030	.		
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Dr. Sign & Reg. No:112236 Reg. No:112236 Additional Info: DRUG NAME TAB SPIR PNO / ACTON E Dose Route Prequency Info Dr. Sign & Reg. No. / Seal Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Reg. No:112236 Additional Info: Area In-charge	ol Phai y Heart		Ī	Frequency	18.00		*	2000	 	7	٧-		
Dr. Sign & Reg. No:112236 Reg. No:112236 Additional Info: DRUG NAME TAB SPIR PNO / ACTON E Dose Route Prequency Info Dr. Sign & Reg. No. / Seal Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Reg. No:112236 Additional Info: Area In-charge	Medwa	Loma	Pla			 -				† <i>*</i>	<u> </u>	 Nano	
Reg. No:112236 Reg. No:112236 Stop Date & Time (a (i)) 2 art 9 3 o o o o o o o o o o o o o o o o o o	$ \bar{ }$	· · · · · · · · · · · · · · · · · · ·		Start Date & Time			160	1600	10.20		 	X- V	
Additional Info: DRUG NAME TAB. SPIRAND/ACTONE Dose Route Proposition of the proposit	★	Dr. PRAVEEN Reg. No:	112236		16:00	7	(Jul	190/8	V]	X		
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TAB. SPIRAND/ACTONE Dose Route Frequency 25mg Ph I-I-O Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Reg. No:112236 Additional Info: Area In-charge		Additional Info:	· 		<u> </u>								
TAB. SPIRANDIACTONE Dose Route Frequency 25mg Pb III-0 Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Reg. No:112236 Additional Info: Area In-charge		DRUG NAME					10.10	10.00	[0-00	10.30	L		
Dr. PRAVEEN JEYAKUMAR Reg. No: 112236 Stop Date & Time 17:00 Additional Info: Area In-charge		TAB. SPIF	NOTJA LONAS	E	10:00		000>		por	R			
Dr. PRAVEEN JEYAKUMAR Reg. No: 112236 Stop Date & Time 17:00 Additional Info: Area In-charge	สเทส สน เกรบ์	Dose	Route			ļ	ļ .			ءد			ļ
Dr. PRAVEEN JEYAKUMAR Reg. No:112236 Stop Date & Time 17:00 Additional Info: Area In-charge	agy He. Te.				<u> </u>						1 8	KOV.	<u> </u>
Reg. No:112236 Stop Date & Time 10 112 3 at 1 2 3 2 4 1 2 2 2 4 1 2 2 2 4 1 2 2 2 4 1 2 2 2 4 1 2 2 2 4 1 2 2 2 2	φφ. 					 >	130	M	I'	, .	 	ļ	
Additional Info: Area In-charge		_		Stop Date & Time	17:00	<u> </u>	17/10		80/20/	4	<u> </u>		—
Area In-charge	X			10/11/23 01 7.30	1	 	ļ	ļ		ļ	ļ		ļ
					-	1	1	-0/		1		-	
I nurse signature:		Area In-charge Nurse Signature	e:			14	1 1/2		KYX	(Par	1		

Clinical Pharmacist Medway Heart institute

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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 ↓ alulation a **DRUG NAME** 8:00 TAB DUZEM-SR Route Dose Frequency 90mg 1-0-1 Start Date & Time Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR 6/11/23 AT NO 40 20:00 mus Stop Date & Time Reg. No. 112236 Additional Info: **DRUG NAME** 8:00 TAR BEPLEX FORTE Dose Route Frequency Jab Dr. Sign & Reg. No. / Seal Start Date & Time 7 1123 AT 8.30 Dr. PRAVEEN JEYAKUMAR Stop Date & Time Reg. No:112236 Additional Info: **DRUG NAME** T- RUSOVASTANN Dose Route Frequency Pc D-0-1 40,00 Start Date & Time Dr. Sign & Reg. No. / Seal 7/11/23 21-00 Dr. PRAVEEN JEYAKUMAR 21:00 Reg. No:112236 Stop Date & Time-Additional Info: **DRUG NAME** 9.00 T. HETOPROLIL (BETMEC) 0:00 Dose Route Frequency 1-0-1 25mg Start Date & Time Dr. Sign & Reg. No. / Seal 7/11/23 Dr. PRAVEEN JEYAKUMAS 21100 Stop Date & Time Reg. No: 112236 Additional Info: **DRUG NAME** 9.00 PREMABUN Route Dose Frequency Pln 1-0-Dr. Sign & Reg. No. / Seal Start Date & Time 11 0 માતાઝ@ 21,00 Stop Date & Time Additional Info: Area in-charge Nurse Signature:

Clinical Phermacist

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Medway Heart institute

Clinical Pharmacist

Clinical Pharmacist

Date -> To be filled by Nursing Staff only. Sign and time given **REGULAR PRESCRIPTIONS** 10/K To be filled in by Doctors only Time ↓ d **DRUG NAME** °00.€ T. JUA BRADINE 1.30 Route Frequency Dose 5 mg 90 1-0-1 Start Date & Time Dr. Sign & Reg. No. / Seal 10/11/23 9.00 Stop Date & Time do oo Additional Info: **DRUG NAME** 3.00 T. LASILACTONE Route Frequency Dose 20/50 Po 1/2-0-0 Dr. Sign & Reg. No. / Seal Start Date & Time 10/11/22 9.00 Stop Date & Time Additional Info: **DRUG NAME** Route Dose 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** Dose Route Frequency Dr. Sign & Reg. No. / Seal Start Date & Time Stop Date & Time Additional Info: Area In-charge Nurse Signature:

Clinical Pharmacist Medway Heart Institute

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Clinic

TAM. CFFURAXIME SODIUM Route Frequency Dose Q12# 1.59 Dr. Sign & Reg. No. / Seal Dr. PRAVEEN JEYAKUMAR Start Date & Time Reg. No:112236 Stop Date & Time 7/11/25 at 18:40 Additional Info: **DRUG NAME** Dose Route Frequency Dr. Sign & Reg. No. / Seal Start Date & Time

ANTIMICROBIALS

To be filled in by Doctors only Time **DRUG NAME** 5:40 61123 AT 17.40 17:40 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** Dose Route Frequency Dr. Sign & Reg. No. / Seal Start Date & Time Stop Date & Time Additional Info: DRUG NAME Dose Route Frequency Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: Area in-charge **Nurse Signature:**

Date →

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

PARENTERAL INFU				ISION F	PRESCRIPTION AND ADM	INISTR	ATION I	RECORD					
D-4-	T:	Intravenous	Malum a	Rate /		Additive Drug			Do	ctor	Adr	ninistratio	n
Date	Time	Fluid	Volume	Duration	Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign.
6/11/23	1420D	KABILYTE	500 m	200 milhr	IV		_	_	F	طندداا	14:00	16:20	
4n123	16:30	KABILYTE.	500ml.	200milho	Zv_	-		-	۶	112211	16:30	00:00	Mar
6/4/23	xo.oo	KABILVIE	Sagul	Your lfx	1.V	. ~	_		_\$_	112216	20.00	1.00	Jain Lory
x[n[23	l		HOOH	trout ha	lv	•		-	8	112231	100	6000 9	601 0034
7/11/23	23.00	•	500m	100ml hr	ŢŲ			-	¥.	112256	23.00	3:00	Ja Te
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0	<u></u> _	Intravenous	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Rate /		Additive Drug			Do	ctor	Adn	ninistration	1
Date	Time	Fluid	Volume	Duration	Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sign
6/11/23	J3:00	N30.9 %	254	Auller	W	INY NITROGILY CERINE	Jing	•	٢	112236	43.00	7/11/23	Bull 1004
<u> ज्यापिक</u>	9.3D	N9 0.9%	50m1	dsmilh	- Dv	2nj. Cordarane	300mu	-	۴	112234	9-30	8 lyb3	d
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		DIE	T ORDERS	(to be pre	escribe	d by Dod	ctors only)		
Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
611/23	20:30	NPO Liquid dist	ţ	112236					
41112	9,00	liqued dier	•	112236					
98/11 B	9-00	Sofi Sup DIET	8	112236	· · · · -				
911123	9:00	Normal det	K4	183267					
10/11/23	9:00	promas stell	2	163263					

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				10/1/2	Morning	Para Juli	2711	ov.
6 (123	Evening	MA HACALSHMI-M	Dala	Qv.		Evening			
6/11/23	Night	Mayin FLORANCE: 8	00-84	his		Night			
111123	Morning	MAHACAUSHARI - NY	Daia	you		Morning			
7/11/02	Evening	19-PRIYON KA	0139	lop		Evening			
7 11 52	Night	Sathiya Vani. N	0265	a dis		Night			
8/11/2	Morning	SMETERN D	0270	-9		Morning			
atula	Evening	M. Daipe	OBL	8		Evening			·
8/11/03	Night	F. lattoure	०२०म	F.C		Night			
9/1423	Morning	M. Sueuls	2200	m		Morning			
alula	Evening	H. Davila	062	On.		Evening	:		
9/11/23	Night	E- cathrine	0207	J.C		Night			₹ .

OPCABX 24RAFTS LMA-> LAD LRA-> OM







	Mr.SOMASUNDARAM 47/Male/MH1202379692	M]	М	HI/ICU/2022/076
Name	05/11/2023/IPH202302:9	90	}		Sheet No.
UHID No.	Dr.Rajesh.v		Age	Sex	
Blood Grou	P. POSITIVE	Height	Weight	BSA 6 1.75ho	Α

SURG	ICAL PR	OCEDU	JRE:					DA	TE OF S	URGERY	4: 06	11/28	•	PC	ST-OP E	AY: 🕦	<u>ک</u> 0	
DATE	TIME					VENTIL	ATORS P								BLOOD	GAS		
DATE		MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	MV	ITV	ETV	FiO,		рН	PCO ₂	PO,	HCO₂	SAT%	BE_
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GOT RECEIVED FROM OT AT 14.00 PATIENT

01 URING: 150 ml.

NEURO

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

VERBAL

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

MOTOR

Br-Brisk

SI-Sluggish

O-Ahsent

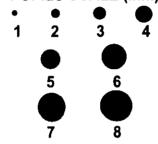
Obey commands-6 Localise pain-5 Non-localising-4 Abn.Flexion-3 Abn.Extension-2 No response/flacid-1

CAPILLARY REFILL

MOTOR ARMS/LEGS

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

PUPILS SCALE (mm)



PUPILS REACTION

Br-Brisk SI-Sluggish O-Absent

CARDIOVASCULAR

O-Absent	O-Abaçını
HEART SOUNDS	NECK VEINS
S1 S2	JVP
M-Murmur	N-Normal
Rb-Rub	In-Increased

G-Gallop SM-Sound muffled

EDEMA

D-Dependent G-Generalised O-Absent

CK VEINS 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

BO	W	EL	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

Mr.SOMASUNDARAM

47/Male/MHI202379692

Sheet No.	Name UHID No.	p		\ge	Sex
В	Blood Grou	,	Height	Weight	1.75 m







				BIOCH	EMISTRY					VITA	L PARA	METER	S			CARDI	AC ASSIST	DEVICE	
DATE	TIME	Hb	Na	к	Ca SUGAR	BLOOD	TIME	ETCO,	BREATH SOUNDS	Sao,	RR/MT	N DD	TEMP°E	Abd [∞] G	TIME	IABP		PACEMAK	ER SETTING
		110	140	ļ-	SUGAR	ВСООВ	IIVIC	2100,	SOUNDS	3802			ILEIVIFF	ADU G	IIIVIE	RATIO	DURATION	RATE	MODE
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NEURO	VERBAL		H	\$	۲	
Ä	MOTOR		5	6	6	
	ARMS R/L		who	81-	SF	
	LEGS R/L		wk	3+	gt	
PUPILS	R.SIZE/REACTIION		3/10	3/80	367	
2	L.SIZE/REACTION		3 8	3/80	3/87	
AR	HEART SOUNDS		&S2	યુક્ટ	5,82	
, scur	VALVE CLICK		-		-	
CARDIO-VASCULAR	CAPILLARY REFILL		BY	Bo	By	
ARDIC	EDEMA		0	0	O	
	NECK VEINS		2	N	И	
 ARY	WORK OF BREATHING		AT	41	AP	
PULMONARY	SUCTION		-		_	
<u>a</u>	SECREATIONS		_			
 AL	BOWEL SOUNDS		+	+	ŧ	
STIN	ABDOMINAL TONE		Soft	90	S	ļ
N T	N/G POSITION		-	,—	-	
GASTRO INTESTINAL	GASTRIC RESIDUAL		•		-	
GA	LIVER		N	N.	H	

	SHIFT	D	AY	EVE	NING	NIC	SHT
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	POSITION CHANGE			Oett	9264	QUH	
MISCELL	CHEST-PHYSIO			NºB ZDIRO	NEB Spiri	100 mg	
MIS	ACTIVITY			P2	pq	P.E	
			<u></u>	ABO	部	ON P	
	S/N NAME			guga 19	Muha	Jave	
	TIME			14,50	18:00	90,00	
	SIGNATURE			Sil	194	Opus	







Mr.SOMASUNDARAM M 47/Mulc/MHI202379692]	M	HI/ICU/2022/076
Name 05/11/2023/IPH202302:90			Sheet No.
UHID No	Age	Sex	
Blood Group Height A POSITIVE ISBU	Weight	BSA 1.75 n3	С

		UR	INE		CI	IEST D	RAINA	3E		GAS	TRIC	LAB S	AMPLE	TOT.	Vou	UM &	INFUSIONS	
DATE	TIME	AMT	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	АМТ.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT	Ant	TOTAL		
06/11/23	14:00														KAB	wrz		
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	21.00	upo	890		40-			40	300_				2.0	1192	KABI	VIE Leon		 _ 2
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	33.00	100	1060		50			50	370				9.0	1432	100	1200	NIG JEVE	

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

ACT: 116 See

GE	NITOURINARY (GU)		SKIN						
	PD		COLOUR	SURGICAL (SX) WOUND	DRESSING				
URINE	FUNCTION	DRAINAGE	Pk-Pink F-Flushed P-Pale	C-Clean Oz-Oozing G-Gaping	B-Betadine Al-Antibiotic Irrigation				
CL-Clear T-Turbid	Dr-Draining B-Blocked	CL-Clear BS-Blood	Cy-Cyanotic M-Mottled	Op-Open I-Infected	mgadon				
Stained HC-High Coloured	SITE		D-Dusky J-Jaundice						
BS-Blood Stained HA-Haematuria	D Dodnood			PRESSURE SORE SITE AREA DRE					
!	MISCELLANEOUS		S-Sacrum Sc-Scapular	R-Redness BD-Black discoloration	IR-Infra Red DU-Dueodem				
OISITION CHANGE	CHEST PH	IYSIO .	Oc-Occiput	BL-Blister SP-Skin Peeling	E-Eptoin dressing B-Betadine dressing				
Su-Supine RL-Right lateral LL-Left Lateral V-Vibrator CP-Chest percussion DC-Deep breath & coug N-Nebulizer		reath & cough		D-Deep	EU-Eusol sitz bath ST-Sofra Tulle				
ACTIVITY			CONDITION						
PE-Passive exercise	TRANSDU	CER ZERO	H-Healing						
Am-Ambulated	PARAMETI ABP-Arteria		SCo-Status quo S-Sloughing						

ABP-Arterial BP
RAP-Right Arterial Pressure
PAP-Pulmonary Arterial Pressure
LAP-Left Arterial Pressure

LINES / TUBES CONDITION

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

CKIN

MI.SOMASUNDARAM M

47/Malc/MHI202379692

							_	
Name	05/11/20	23/1PH202302190					SI	heet No.
	Dr.RAJES			_				, - -
UHID No	<u> </u>				ge	Sex		(1)
Blood Gro	oup		Height	—	Weight	BSA		
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FLUID ASSESSMENT (contd.)

HAEMODYNAMICS

Blood Group: 💸

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DATE	TIME	INF	USIONS (d	contd.)	TOTAL	_	/ORAL	TOTAL	TOTAL BALANCE	HR/mt	RYTHYM	СТ	ABP	MAP	RAP	LAP/	PERI	PP	со	CI	SVR
						AMT.	TOTAL	INTAKE	BALANCE	11101111		"	ADI	IVIA	IVA	RAP	1 (21%)	R/L	- 00	Ŭ,	J
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STAT DRUGS TIME	PREVIOUS DAY HRS
IIME	DRAINAGE: TOTAL INTAKE:
	URINE : TOTAL OUTPUT:
	TOTAL BALANCE:

	DAY	EVENING	NIGHT
PATIENT CARE	-		
BATH			
ORAL CARE			
EYE CARE			
BACK CARE	-		
DRESSING/EQUIPMENT			
CHANGED			
WOUND			
CEN.LINE			
I.V.SET			
TUBINGS			
HUMIDIFIER H2O			
ELECTRODES			
ALARMS VERIFIED .			
VENT - HUMIDIFIER			
-SETTINGS			
HRT.RATE		756m	
B.P.		114/71 mm	

DATE	TIME	REMARKS / PLAN	

INFUSION PU	MPS						
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
JIV		6 11 23	•	-	ļ <u>-</u>	P	P
ARTSRIAL LINS	RT _O	6/11/23	1			p	P
BERI LINE	RT CUBITAL	6/11/23	١.			P	P
IV SXTN		t 11/23.				P	P
MEDIASTINA		6/11/23	1	_		10	P
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OPUAB X & YRAFTS
LIMA > LAD
LRA -> CM

Medway Hospitals

The way to better health
(A Unit of United Alleren Limits)





		Mr.SOMASUNDARAM M 47/Malc/MHI202379692]_		M	HI/ICU/2022/076	
	Name	05/11/2023/IPH202302190					Sheet No.	
; ;	UHID No.	Dr.Rajesh.v	A	ge	Sex	0		
	Blood Grou	A POSITIVE	Height	~	Weight 국어 년	BSA 1-7-5-W	Α	

SURGICAL PROCEDURE:

DATE OF SURGERY: DLU 23 POST-OP DAY: 7 POD

3010	IICAL PR	COLDO	· · · · · · · · · · · · · · · · · · ·					DA	EUFS	UKGEKI	. 001	11123		PC	SI-OF L	JAT: T	100	
			_			VENTIL	ATORS P	ARAMET	ER\$						BLOOD	GAS		
DATE	TIME	MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	ΜV	IT∨	ETV	FiO ₂		pН	PCO ₂	PO _z	HCO ₂	SAT%	BE
4/11/23	10.00		ON	Nasal	PRO	Ngs					NGF							
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	6.00	(24	Roc	H 8	(rR							- 1 -410	39·A	66.A	JA.A	93·A	6.2
											<u></u>							

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

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

MOTOR ARMS/LEGS

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

PUPILS SCALE (mm)

•	•	
1	2	3
	5	6
	7	8

PUPILS REACTION

Br-Brisk
SI-Sluggish
O-Absent

CARDIOVASCULAR

D-Dependent

G-Generalised

EDEMA

O-Absent

Br-Brisk SI-Sluggish O-Absent

CAPILLARY REFILL

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

NECK VEINS

JVP N-Normal In-Increased

VALVE CLICK/ SHUNT NUMBER

Valve Replaced / Shunt +Present O-Absent

PULMONARY

WORK OF BREATHING	
Ab-Abdominal	
TA-Thoraco-abdomial	

TA-Thoraco-abdomial L-Laboured

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

SUCTION

N-Nasal

Or-Oral

ET-Endotracheal

GASTRIC RESIDUAL

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

Mr.SOMASUNDARAM N.

47/Malc/MHI202379692

			1.			
	Name 05	/11/2023/IPH202302:90) [-		· ·	_
Sheet No.	Dr	.RAJESH.V	1			
رل	UHID No _	<u>iki aman bila man balika kimin di</u> ili kabab kama didi		Age	Sex	
В	Blood Group	. 4v€	Height	Weight	BSA	







				ВІОСН	EMISTRY					VITA	L PARA	METER	S			CARDIA	AC ASSIST	DEVICE	
DATE	TIME	НЬ	Na	к	Ca SUGAR	BLOOD	TIME	ETCO,	BREATH SOUNDS	_	RR/MT	I	Ĭ	Abd sm G	TIME	IABP		PACEMAKE	R SETTING
<u> </u>		, ,,,,	,,,,	<u> </u>	SUGAR	BLOOD	1,114112		SOUNDS	+			ļ	ADG G	111111	RATIO	DURATION	RATE	MODE
7/1/23							00.00		c\	a91/·	20/nt		98 F						_
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							2.00		راي	93%	28 Jul								
							3.00				whit								
							A.00				MILES		ax.A°F						
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	6,30	14.)	136	4.18	1.08		6.00		cl	98%	whit								
					ļ		4.00		cl		≈/ut								Chin TA

	SHIFT	DAY	EVENING	NIGHT
	TIME			∞ .∞ ∞.∞
	EYES			A A
NEURO	VERBAL			6 6 7 6 F
	MOTOR			6 6
	ARMS R/L			st 3k
	LEGS R/L			st st
PUPILS	R.SIZE/REACTIION			3/87 3/87
PUE	L.SIZE/REACTION			3/67 3/67
AR.	HEART SOUNDS			5152 5172
CUL	VALVE CLICK			
CARDIO-VASCULAR	CAPILLARY REFILL			B4 B4
RDIC	EDEMA			0 0
3	NECK VEINS			NN
ARY	WORK OF BREATHING			JB JB
PULMONARY	SUCTION			
P.O.	SECREATIONS			
₩	BOWEL SOUNDS			+ +
STIN	ABDOMINAL TONE			2 9
N N	N/G POSITION			
GASTRO INTESTINAL	GASTRIC RESIDUAL			
GAS	LIVER			7 4

	SHIFT	DAY	EVENING	NIC	SHT
	DESCRIP.OF URINE			cl	cl
G.U.	PD - FUNCTION			~	-
	DRAINAGE			-	_
	PD - SITE			-	-
	COLOUR	<u></u>		-	-
	Sx WOUND-CHEST			c١	c١
	LEG			ری	cl
SKN	DRESSING			os_	10
	PRESSURE SORE-SITE			1:1	1:1
	AREA			-	_
	DRESSING CONDITION			_	_
	POSITION CHANGE			ONH	O_{N_T}
MISCELL	CHEST-PHYSIO			1000	2,5
MIS	ACTIVITY			φ,ε 2,9	3.6
				CVP	ESS.
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	TIME			00.00	OV. Do
	SIGNATURE			Sout	daŭ







M	r.:	S	O)	1	A	u	3	U	I	V	D	Α	R	A	M	M

POSITIVE

Age

Weight

Height

Sex

BSA

47/Malc/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V

Name

Blood Group

UHID No.

MHI/ICU/2022/076 Sheet No.

		UR	RINE		CI	HEST D	RAINAG	E		GAS	TRIC	LAB S	AMPLE		VOLU	ME	INFUSIONS		
DATE	TIME	АМТ	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	AMT.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT			NTG		
4/11/03	∞.∞	20	1199			30		3 0	400				2.0	1532	I p o	1300	1 1		
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	2.00	10	Bir						A20				2.0	1697	KABI	1500	3.0		
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	2.00	40	1220			ļ. <u></u>		,	470			1.0	8.0	2198		1900		<u> </u>	
							_			_			_						_

SPECIFIC OBSERVATIONS/PROBLEMS

DATE	TIME

CRITICAL CARE FLOWCHART

GENITOURINARY (GU)
------------------------	-----

	PD		COLOUR	SURGICAL (SX) WOUNI	D DRESSING			
URINE	FUNCTION	DRAINAGE	Pk-Pink F-Flushed P-Pale	C-Clean Oz-Oozing G-Gaping	B-Betadine Al-Antibiotic Irrigation			
CL-Clear T-Turbid	Dr-Draining B-Blocked	CL-Clear BS-Blood	Cy-Cyanotic M-Mottled	Op-Open I-Infected	mgation			
Stained HC-High Coloured	SITE		D-Dusky J-Jaundice					
BS-Blood Stained HA-Haematuria	C-Clean R-Redness		PRESSURE SORE					
TIA-Hacmatana	BD-Block discoloration	1	SITE	AREA	DRESSING / Rx			
ı	MISCELLANEOUS		S-Sacrum Sc-Scapular	R-Redness BD-Black discoloration	IR-Infra Red DU-Dueodem			
OISITION CHANGE	CHEST PH	YSIO	Oc-Occiput	BL-Blister SP-Skin Peeling	E-Eptoin dressing B-Betadine dressing			
Su-Supine	V-Vibrator			D-Deep	EU-Eusol sitz bath			

Su-Supine RL-Right lateral LL-Left Lateral

ACTIVITY

PE-Passive exercise Am-Ambulated V-Vibrator CP-Chest percussion DC-Deep breath & cough N-Nebulizer

TRANSDUCER ZERO

PARAMETER
ABP-Arterial BP
RAP-Right Arterial Pressure
PAP-Pulmonary Arterial Pressure
LAP-Left Arterial Pressure

CONDITION

H-Healing SCo-Status quo S-Sloughing

LINES / TUBES CONDITION

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

ST-Sofra Tulle

Mr.SOMASUNDARAM M

47/Male/MHI202379692

Name

05/11/2023/IPH202302:90

Dr.RAJESH.V

UHID No Blood Group

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1 <u>1510 1889 1811 17</u> 44 1861 <u>1111</u>					9
	Height	Weight	BSA		<u> </u>
POSITIVE	158 cm	HO EV	(1750	R_ D	U

Age

Sex







FLUID ASSESSMENT (contd.)

HAEMODYNAMICS

Sheet No.

POSITIVE **Blood Group:** INFUSIONS (contd.) N/G/ORAL TOTAL TOTAL |HR/mt||RYTHYM| PERI CO **SVR** DATE TIME ST **ABP** MAP RAP TOTAL INTAKE BALANCE RAP R/L AMT. TOTAL UISC 102 SINUS 116 P.0 1573 **160** CODIN HT **CRITICAL CARE** P. 0 350 1678 nЯ 1.0 SHUSINOF Vooru Ht 2.00 5.0 TOF 1483 200 (cuns 486 20 10 MYM 12 3'00 9.0 E.O 200 88 105 +81 almo? MYRU NFP A.00 K.0 1093 2.0 102 mym to **FLOWCHART** 5.00 9.0 **5**0 SIMIS 4113 100 mym ++ FUNISI 3.0 6.00 11 108 LI MYON ₹.00 1415 MIDON M HA 400 2349 10.0 K U/11/2 4.0 100

STAT DRUGS	•	PREVIOUS DAY	HRS	
TIME		DRAINAGE:	TOTAL INTAKE:	
		URINE:	TOTAL OUTPUT:	1
		,	TOTAL BALANCE:	<i>></i>

P.T.O.

	DAY		
	DAY	EVENING	NIGHT
PATIENT CARE			
ВАТН			/
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			LESON
B.P			14/185

DATE	TIME	REMARKS / PLAN	while.

INFUSION PU	MPS						
LINES/TUBES	SITE	INSERTION DATE	DAYS	INFUSION/ DRAINAGE	DAY	EVE	NIGHT
VET		6/11/23	1		<u> </u>	ļ	P
ART-LINE		6/11/23	1				3
PERI LING	RT EUBUA	1.6/11/23	1		<u> </u>]	P
IV EXIN.		blule 3			<u> </u>		P
MEDIA		6/ul23	•		<u> </u>		P
PLEURA	1_7	6/11/23	1		<u> </u>	ļ <u>.</u>	P
U-CAÎH	ļ	6/11/23	1_		<u> </u>	<u> </u>	P
TR-DOME		6/11/23	1		<u> </u>		P
02.7UBM4		611123	١		 _ _		P
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	<u></u>		<u> </u>	<u>.</u>	<u>L_</u>	<u>L</u>	<u> </u>

OPUAB X QURAFES LIANA->LAD LRA->OM

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





	Mr.SOMASUNDARAM M 47/Malc/MHI202379692]		ħ	1HI/ICU/2022/076
Name	05/11/2023/IHH202302190		ľ	_		Sheet No.
UHID No.	Dr.RAJESH.V		A.	је	Sex	3
Blood Gro	A DOSITIVE	Height	- 	Weight けんし	BSA	Α

SURGICAL PROCEDURE:

DATE OF SURGERY: 10 6/11/23 POST-OP DAY: 1000

		CCLDC						אל	12 01 30	JI CEIC	00,	. ((\/ /			01-01 1		YUY	
						VENTIL	ATORS P	ARAMET	ERS						BLOOD	GAS		
DATE	TIME	MODE	RATE	PRESS SUPPORT	PEAK PRESS	PEEP	MEAN PRESS	ΜV	IT∨	ETV	FiO ₂		рН	PCO ₂	PO ₂	нсо,	SAT%	BE
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		 														!		
															<u> </u>			
		!		<u> </u>														

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

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

MOTOR ARMS/LEGS

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

PUPILS SCALE (mm)

2 8

PUPILS REACTION

Br-Brisk SI-Sluggish O-Absent

CARDIOVASCULAR

CAPILLARY REFILL

D-Dependent Br-Brisk SI-Sluggish O-Absent O-Absent

HEART SOUNDS

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

EDEMA

G-Generalised

NECK VEINS

JVP N-Normal In-Increased

VALVE CLICK/

Valve Replaced / Shunt +Present O-Absent

SHUNT NUMBER

PULMONARY

WORK OF BREATHING

Ab-Abdominal TA-Thoraco-abdomial L-Laboured

SUCTION

ET-Endotracheal N-Nasal Or-Oral

CHARACTER

BREATH SOUNDS

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

SECRETIONS

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

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

LIVERSIZE

N-Normal E-Enlarged Mr.SOMASUNDARAM M

47/Malc; MHI202379692

Height

		,	
Sheet No.	Name	05/11/2023/IPH202302190	
Silect No.		Dr.RAJESH.V	l
	UHID No	110 TH 110 TH 110 THE BEST 120 THE STATE THAT IS SHE SHE	Age

MI POSITIVE

Blood Group

В

ge	Sex	Me
Weight	BSA	T







				ВІОСН	EMISTRY			-		VITA	L PARA	METER:	<u> </u>			CARDIA	CARDIAC ASSIST DEVICE			
DATE	TIME	Hb	Na	к	Ca SUGAR	BLOOD	TIME	ETCO,	BREATH SOUNDS	Sao,	RR/MT	N,BP	TEMP⁰F	Abd ^{c™} G	TIME	IABP		PACEMAK	ER SETTING	
	-	-			SUGAR			-	SOUNDS	<u> </u>	Ĺ	<u>'</u>	-			RATIO	DURATION	RATE	MODE	
1/11/23							8:00		U	97%	300]		L				
							8:00		J	201	32 mt		97.99							
							60.00		U	aus.	30/m									
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							12.00		u	961	Zolmt		944					_		
							18 00		cl	95.1	ω	80 (42								
				_			14.00		cl	944	arlm	102	8)							
							15·00		cl	961	2Hop	nose	101 94 AF							
							16.00		cl	97/	28 hr	11/3	83)		J				_	
							17°00		cl	99.1.	30 bpr	120	(100)							

CRITICAL CARE FLOWCHART

	SHIFT	D.	AY	EVEN	ING	NIC	SHT
	TIME	8100	12an	16.00			
	EYES	ч	4	A			
NEURO	VERBAL	5	5	Š			
뿐	MOTOR	Ь	Ь	Ь			
	ARMS R/L	3+	ST	st			
	LEGS R/L	3+	297	st			
PUPILS	R.SIZE/REACTIION	3/88	3 BK	31B8	_		
In a	L.SIZE/REACTION	3/80	'31 B k	31BR			
AR	HEART SOUNDS	5152	5132	S 182			
) COL	VALVE CLICK		-	-			
CARDIO-VASCULAR	CAPILLARY REFILL	Br	Be	Be			
\RDIC	EDEMA	_		0			
	NECK VEINS	-	_	N			
 ARY	WORK OF BREATHING		TA	Tn			
PULMONARY	SUCTION	_					
<u>a</u>	SECREATIONS	_		_			
]AL	BOWEL SOUNDS	4	+	+			
STIN	ABDOMINAL TONE	50	Soft	SOFI			
N TE	N/G POSITION	_	•				
GASTRO INTESTINAL	GASTRIC RESIDUAL	_	-	-			
₽ B	LIVER	Ν,	1	N			

	SHIFT	Di	AY	EVE	NING	NIC	SHT
	DESCRIP.OF URINE	U	Ų	વ			
G.U.	PD - FUNCTION	ł	1	1			
	DRAINAGE	1	•-	1			
	PD - SITE	l (•-			
	COLOUR	ì	_	1			
	Sx WOUND-CHEST	3	دل	cl			_
	LEG	3	دار	ठ			
SKN	DRESSING	ot	OT	9			
	PRESSURE SORE-SITE	1	-	NIL			
	AREA	ı	-	1			
	DRESSING CONDITION	·	-	-	l		
	POSITION CHANGE	Q2 H	(L)	(D24)			
MISCELL	CHEST-PHYSIO	<u>ver</u>	NIBP	SOPE			
WIS	ACTIVITY	PZ	PE	PE			
		CUP	MBP	NIBP			
	S/N NAME	Man	Dans	(A)			
	TIME	8:00	12 as	1600			
	SIGNATURE	Di.	4	P			







	Mr.SOMASUNDARAM M 47/Male/MHI202379692		_		М	HI/ICU/2022/076
Name	05/11/2023/iPH202302i90		l ⁻			Sheet No.
UHID No.	Dr.Rajesh.v		_ A	ge	Sex	3
Blood Grou	POSITIVS	Height	200	Weight	BSA	С

		UR	INE		CI	IEST D	RAINAC	3E	_	GAS	TRIC	LAB S	AMPLE	TOTAL	VOL	MĒ	INFUSIONS	
DATE	TIME	АМТ	TOTAL	RT.PL.	LT.PL.	MED	PERIC	HR.T	G.T.	АМТ.	TOTAL	AMT.	TOTAL	TOTAL OUTPUT	AMĪ	36		
1/11/29	9,00	100	100		30			30	30				<u></u>	130				
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,	00:00	60	310		R				50					390				
	1:00	95	105						50					485				
	1300	9p	495						50					575	KAE	BIL-YE		
	13.00	80	5 †5						50					655	200	200		
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	15.00	80	755		ļ				50					835		200		
	16.00	100	855						50					935		200		
	H-00	80	905	l					50	i				1015		200		

9.50 MEDIASTINAL AND LEFT PLEURA DRAIN WAS REIGOVED SPECIFIC OBSERVATIONS/PROBLEMS

DATE TIME 10.80 ARTERIAL LINE WAS REMOVED (DaJAIGIANESHI)

G	ENITOURINARY (GU)			SKIN	
	PD		COLOUR	SURGICAL (SX) WOUN	DRESSING
URINE	FUNCTION	DRAINAGE	Pk-Pink F-Flushed P-Pale	C-Clean Oz-Oozing G-Gaping	B-Betadine Al-Antibiotic Irrigation
CL-Clear T-Turbid	Dr-Draining B-Blocked	CL-Clear BS-Blood	Cy-Cyanotic M-Mottled	Op-Open I-Infected	ingaton
Stained HC-High Coloured	SITE		D-Dusky J-Jaundice		
BS-Blood Stained HA-Haematuria	C-Clean R-Redness BD-Block discolorati	ion	SITE	PRESSURE SORE	DRESSING / Rx
	MISCELLANEOUS		S-Sacrum Sc-Scapular	R-Redness BD-Black discoloration	IR-Infra Red DU-Dueodem
OISITION CHANGE	CHEST F	PHYSIO	Oc-Occiput	BL-Blister SP-Skin Peeling	E-Eptoin dressing B-Betadine dressing
Su-Supine RL-Right lateral LL-Left Lateral		t percussion breath & cough		D-Deep	EU-Eusol sitz bath ST-Sofra Tulle
ACTIVITY			CONDITION		
PE-Passive exercise Am-Ambulated	TRANSD PARAME		H-Healing SCo-Status quo S-Sloughing		

PARAMETER ABP-Arterial BP

RAP-Right Arterial Pressure PAP-Pulmonary Arterial Pressure LAP-Left Arterial Pressure

S-Sloughing

LINES / TUBES CONDITION

O-No redness, swelling, no leak, no air

CKIN

R-Redness at site Sw-Swelling at site

Dr-Draining D/c-Discontinued

P-Positional

HL-Heparin Lock B-Blocked

Mr.SOMASUNDARAM M

47/Male/MHI202379692

	, , , , , , , , , , , , , , , , , , , ,	0,3032	1		
Name	05/11/2023/тен2	02302190			Sheet No.
	Dr.RAJESH.V				Greet No.
UHID No.	AND THE SAME OF TH	TIL JABAH MASA SINA MASA 194	Age	Sex	(<u>e</u>)
Blood Grou		Height	Weight	BSA	D
	A A	CSITIUS 1580	m +70 las	1 1 Hom	





Blood Group:



FLUID ASSESSMENT (contd.)

HAEMODYNAMICS

					. 1001110	,														p ·	<i>-</i>		
DATE	TIME		INFU	SIONS (1	KISC.	TOTAL		/ORAL	TOTAL INTAKE	TOTAL BALANCE	HR/mt	RYTHYM	ST	ABP	MAP	RAP	LAP/ RAP	PERI	PP R/L	СО	СІ	SVR
1/11/23	3:00					2.0		60	60	60	70	100	SINUS	B-00	58 an	·hu	8		uwn	74			
	9:00°	1			<u>۱</u> ۳	2.0		150	210	214	76	}_ '	sinlus		Tun	\ \	٠١ر		vesn	H			
	DiOO	,			4	a-0		100	310	316		98	BLUN	, b·∞	165	116	12		ucum	+1			
	11.00	,						75	385	391	94	85-	Sialus	O: <i>O</i> 1	34	94	10		asm	1+			
	12.00							tea	H85	मेवा		扫	SIM	OK	-		•		سعما	41.			
	13.00	,	<u> </u>					100	585	9 91	136	43	Since	0.01					ww	+1			
	1400	<u> </u>				_			585	नेवा	3h +	निय	Sim	Orcu_					Wans	3.4			
	1500								585	7 91	44	73	Sinus	00			-		wo	44		<u> </u>	
	16.00		<u> </u>					100	<i>b</i> 85	891	44	86	8 1NR	901					wes	++			
	1700							150	835	1041	26	91	BINUS	0.02	17	:			un	+1		<u></u>	

STAT DRUGS TIME

PREVIOUS DAY HRS

DRAINAGE: 4 FOUL TOTAL INTAKE: 434941

URINE: 1720ul

TOTAL OUTPUT: \$198 HI

TOTAL BALANCE: + 181 H

	DAY	EVENING	NIGHT
PATIENT CARE		_	
BATH			
ORAL CARE			
EYE CARE			
BACK CARE			
DRESSING/EQUIPMENT			
CHANGED			
WOUND			
CEN.LINE			
I.V.SET			
TUBINGS			•
HUMIDIFIER H2O			_
ELECTRODES			
ALARMS VERIFIED .			
VENT - HUMIDIFIER			
-SETTINGS			
HRT.RATE	1036 m	7Abpm	
B.P.	161/20m	981 Wamty	,

DATE	TIME	REMARKS / PLAN
		}

INFUSION PU	MDS	_					
		INSERTION	,	INFUSION/	: 	1_]
LINES/TUBES	SITE	INSERTION DATE	DAYS	DRAINAGE	DAY	EVE	NIGHT
73v _		6/11/23	2		2	P	
ART-LING	81 840 81	<u> 6/11/23</u>	2		<u> </u>	R	
DERI LINE	WB!	6/4/23	2_		12	+	ļ
IV EXIN		6/11/23	2_		į.	P	
MEDIA		6/11/23	2		ÌP_	2	
PLEURA.	15	blules	2		p	P	
U-CATH_		6/11/29	2		12	P_	
TR. DOME		6/11/23	2		p	R	
Co-TUBING	,	blul23	2		P	b,	
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47/Male/MHI202379692 05/11/2023/(PH202302)90

Dr.RAJESH.V





MEDIATE CARE FLOWCHART

NAME:

UHID NO:

AGE:

SEX:

SURGICAL PROCEDURE:

POSTOP DAY: POD - T

OPEAB X 2GRAFTS

LIMA -> LAD

LRA > DA FLUID REQUIREMENT: 2.4 litael day

DATE	UR	INE	CI	HEST D	RAIN	AGE	TOTAL		I.V. F	LUIDS		ORAI	_/ R.T.		TOTAL
& TIME	н.т.	G.T.	•	AIR LEAK	H.T.	G.T.	TOTAL OUTPUT				H.T.	н.т.	G.T.	INTEKE	BALANCE
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9-00								Dij.				75	175	175	4175
10.00	Oor	ට්ග	_				200.	200 50 200 50			· — · <u> </u>	100	J75_		ا ندا
11.00	200	400					ADD	عد ا ر	.			100	अऽ	375 485 325	75
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			 _												
					:										
SPEC	IFIC O	BSERVA'	TIONS/	REMAR			_	MEDI	CATION	I / DRUC	GS				



Mr.SOMASUNDARAM M

47/Malc/MHI202379692 05/11/2023/IPH202302190

Dr.RAJESH.V



REDIATE CARE FLOWCHART

NAME:

POSTOP DAY:

HI (1: 10) H (1: 10) H (1: 10) H (1: 10) H (1: 10) H (1: 10) H (1: 10) H

POD -I

UHID NO:

AGE:

SEX:

SURGICAL PROCEDURE:

OPOAB × 2GRAFTS

LIMA > LAD

TRA - DION FLUID REQUIREMENT: 2.4 little l day

DATE	UR	INE	CH	IEST [DRAIN.	AGE	TOTAL	I.V. FLUIDS			ORAL/ R.T.		TOTAL	TOTAL BALANCE	
& TIME	н.т. G .т.			AIR LEAK H.T.		G.T.	OUTPUT				н.т.	H.T. G.T.			
711123 18:00		1005				50	1115					100	935	1141	4 2b
19 00		1095				50	1205						985	1141	54
<i>₹</i> 0.00	100	1195				50	1305					סמן	035	11451	Бн
2).00	100	1295			,	50	1405					100	1335	1341	- 6н
22.00	סכו	માડ				००	1465						1135	1341	124
2 3.00	200	1615				50	1665			100	4te 100		1135	1441	224
00.00	150	1765				50	1815			100	100		1135	ो⊆ म)	 274
1.00	100	1865				50	1915			100	100	100	1235	1741	174
2.00	130	1990				50	2015		_	100	100		1235	1841	174
3.00	اه دا	2110				50	2135			toU	100		1035	1941	194
400	90	2200				50	2725						1235	204)	184
5.00	-	2200		i		50	2 250					00	(335	2141	109
6.00	·	22 bO				50	2250					too	1435	a a hi	9
7.00		220 [©]				50	2250					100	1535	2341	+91
SPECI	SPECIFIC OBSERVATIONS/REMARKS							MEDICATION / DRUGS							







RMEDIATE CARE FLOWCHART

NAME:

Dr.RAJESH.V 110 MW 1111 MA 100 MA HAW 1111 WAN 1111 WA 1111 WA

47/Male/MHI202379692

05/11/2023/IPH202302190

UHID NO:

AGE:

SEX:

BLOOD GROUP: ATTE

HEIGHT: 158cm

WEIGHT:

B.S.A: 1 . 7m2

HAEMODYNAMICS									P. PARAMET	rers	INVESTIGATIONS /		
TEMP	H.R.	RHY.	ST.	в .Р.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA		
98£	106	CIME	0-01	138/ 64	t call	oar	44	20	CL	92%	ON	loom	Dir.
	los	81 MU	O.a.	121/18	A2)	ion	तन	ನಿ೨	CL	931	.,		
	104	81Ny	اص	130/	(eg)) Wear	नेन	18	Cl	91%			
	8b.	SINKS	Ø-Ø	10/	(91 ⁾	loan	44	14	CL	96/			
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DRAINAGE 50m

URINE 2200 m

PREVIOUS DAY - HOURS 24 his TOTAL INTAKE 2341 m TOTAL OUTPUT 2250 m BALANCET 9) m





UHID NO:



Mr.SOMASUNDARAM M

47/Male/MHI202379692 05/11/2023/:PH202302190

Dr.RAJESH.V

MEDIATE CARE FLOWCHART

AGE:

SEX:

NAME:

BLOOD GROUP: A+ve

HEIGHT:

158cm

WEIGHT:

B.S.A: 1.75 m2

HAEMODYNAMICS									P. PARAME	TER\$	INVESTIGATIONS /		
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA		
77-47	98	Sinus	0.01	139	105	wood	, 4	98	cl	98.1	ON NASAL PRONG.		
 · · ·	99	SIN	001	113	94	wason	++	24	व	99/			
93.5°F	99	Shus	0.02	116	92	warm	+4	lelmi	cſ	96%	ir.		
	93	Syns	0.02	128	91	loarm	++	adm	<i>c</i>)	99%	"		
	92	SINIA	8.03	132	103	warm	++	mlni	ر -	96%	V		
	90 .	gavi	6.02	140 99	416	warm	44	tales	cl	99%	',		
99F		BUR		157	104	evan	44	24/11/	d	99%	4		
	91	Saus	0.02	138 91	99	Water	++	12/nd	cſ	100 %	71		
	96	SMVS	৫৩১	<u>127</u> 7 1	83	wayo	++	4/mf	eľ	100%	7		
	91	Einus	0.01	132	95	harn	++	16 nd	c/	99%	<i>'</i> >		
	91	BUND	0.00	140	101	Naren	++	12/nd	cl	97%	1		
94.54	88	Saus	0.02	(H) 95	1112	Warm	+4	明社	cľ	967	1		
	100	BND	6.03	,		toam	4+	edm	d	٠٧٤	"/		
	106	Sinu	003	128	162	Warn	++	12 m	cl	90%	ON room air		
	}	_		İ									
					- "								
		<u> </u>	<u> </u>					<u> </u>	EVIOUS DAY				

DRAINAGE URINE

PREVIOUS DAY - HOURS

TOTAL INTAKE

TOTAL OUTPUT

BALANCE