

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	/	



MT.KANNAN GOVINDHAN

| 44/Malc/MHI202481768 1 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





Every heart beat counts

The way to better health

ADMISSION SLIP (A Unit of United Alliance Healthcare Pvt Ltd)

Admitting Doctors Description	^ .	Speciality: Card	<u> </u>	
Admitting Doctor: Dyr (thanarcha	Speciality. Ckra	~	 -
	11202 \$ + 12: 10 mm			
Provisional Diagnosis:				
Dγ	D - CAD -			
,				
<u>.</u>				-
Reason for Admission:	Medical Management	Surgical Manageme	ent j	
·	Others (please specify details)			<u>. </u>
Admission Type:	Day Care ER-	☐ Ward		
[Jeo	(Specify details)		
·Surgery / Procedure Name ((if planned):			
	can pay / cher	Any is		
	Yes (Kindly specify	<u></u>		
Blood Floddet Requirement	IND Les (Mindry specify	uetans of components require	sa in space below)	
į				
Expected Duration of Stave	A-3 Do			
Expected Duration of Stay:				
Expected Cost of Treatment	(as per Financial Counseling Form	ų:		
Payer: Self 🗀 Insurance	e Others:			
Instructions to Nurse (if any)	• •			
instructions to Nurse (ii any)) .	•	•	
Ī		CRC Cons.	Same Arrives	
- Jan	+ campact-1	. CBC/ ureal	vicariu	
Any other Instructions (if an	v):			
y and mon zonone (ii an	,,,			
	-			
Doctor's Signature	Name	Reg. No.	Date	Time
· ~	Dr-vel	91268	12/1/28	12-3000
		:		<u>l </u>

For admission desk staff of	only:		
	General Ward Single Room Twin Sharing		
	Deluxe Room Suite Room Others		· · · · · · · · · · · · · · · · · · ·
Admission intimation	Receipt Details	Admission Ti	me in HIS
Date	Time	Date	Time
12/01/2024	01.16 RM	12/01/2024	01.16 AM
To be filled only if Blood	OPD ER Direct requirement specified by the Blood Bank clearance com	•	No
Front office Staff Signature	Name Nlach	Emp. No.	Date Time 12/1/24 01-16 6
	, starki		





Mr.KANNAN GOVINDHAN

44/Male/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





MHI/HOSP/2022/129

ADMISSION FORM

Marital Status	Full Add	Iress: No; 30 B	WEMA COLON	Y, KAMARII	Telephone Number
N)		U BUASHERNEN			98838394670
Occupation	سما	1-8 - Bann	12.7	. -	9003220529
Referred from	1000	Date of Time of Admission	Date & Time of Dischar	ge To	tal No. of Days
Dr. vi)	12/01/24-01.16	14/1/24	~ I	ays .
UNIT	~V.	MLC Yes	No If Yes A	R No. :	
		FINAL DIAGNO	SIS		ICD Code
CAP-E	NOTHE!	INMI CAG	DOUBLE VE	SSEL	725.4
•		PO) CA13X1			725.2
DYSEU	NCTLDN	SYSTEMIC H	LYPER TEINSLE	DIV	250.1
		·	•		210
	*				
DATE		OPERATION /	PROCEDURES		ICPM Code
	NCCE SSE	OL PTCA+STENT TO		B OCIAICO	
1.6.1.2	-5x22 M	Y ONLYX TRUCOR	DES EPROXIMOL I	CXUSING	00.66
121024	-5Y12M1	YONYX TRUCOR	DESE PTCAT S	PENTTOLAN	
		INCH 2.25 X18 M	•		
1	PONIFO	N (12/01/24)	1/04/1/100		
DATE	<u> </u>	TYPE OF A	NESTHESIA		
12/1/24	☐ GENERA	L SPINAL	LOCAL	☐ REGIONAL	☐ EPIDURAL
		DISC	HARGE STATUS		
☐ Cured		☐ Discharge at Requ			Expired < 48 hours
V☐ Improved		☐ Against Medical A	dvice		Expired > 48 hours
☐ Unchange	d	☐ Absconded ☐ Transferred to			Post-Operative Death
DOG G	NAVE	Nu -		Al	<u> </u>
Rev. Signature	1469 The Consul	tant	,	پس Signature of Med	니 역 dical Records Officer

AUTHORISATION FOR TREATMENT I PAYMENT

I hereby authorise the Administration, Medical and Nursing and Paramedical, Staf f of the Hospital Investigate treat and administer such drugs as may be necessary and to perform such operation under anaesthesia or other wise as may be deemed necessary and / or advisable in the diagnosis and treatment of my illness / patient
I hereby under take to settle all the bills for hospitalisation charges related to me/the patient named overleaf on a periodic basis. In any case, I shall pay all the dues before getting discharged from the hospital.
However, in case I fail to pay the charges due to the hospital as agreed above, I hereby authorise the hospital to transfer me/the patient to any other hospital/institution for further treatment as deemed fit and proper by the hospital authorities.
I also acknowledge having been informed if the General Rules and Regulations of the Hospital and that all cash, jewellery and valuables belonging to the patient or theis attendants have been removed to a place of safety / handed over to the next of kin and I absolve the hospital of any responsibility with regard to any loss.
I have read out and explained the contents of the above to the Signatory in his vernacular .
சிகீச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்
இதன் மூலமாக நான் நீா்வாகம், மருத்துவம், தாதியா், ஏனைய மருத்துவ ஊழியா்கள் எனக்கு / நோயாளி க்கு தேவைப்பட்ட சோதனைகளை செய்து மருந்துகளை கொடுக்கவும். மயக்க மருந்துகள் கொடுத்து செய்முறைகள்/அறுவை சிகீச்சை செய்யவும் அதிகாரம் வழங்குகீறேன். நான் / இதில் குறித்துள்ள நோயாளின் செலவுக்கன தொகை முழுவதும் செலுத்த இதன் மூலம் உறுதி அளிக்கீறேன்.
மேல் கூறியது போல் வேளை நான் தங்கள் மருத்துவத்திற்கான செலவுகளை கட்டத் தவறினால் என்னை நோயாளியை வேறொரு மருத்துவமனைக்கு, பிற சிகீச்சை / அறுவை சிகீச்சை செய்ய இடமாற்ற ஒப்புதலை எனது உறவினர்கள் மூலமாக பெற நான் அதிகாரம் அளிக்கிறேன்.
மருத்துவமனையின் பொது சட்ட தீட்டங்கள் பற்றி தெரிவிக்கிப்பட்டிருக்கிறேன்.
நோயாளிக்கு உரிமையான எல்லா பணம், நகை மதிப்பிடக்கூடி பொருட்கள் யாவும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்லு நெருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ளது. இந்த மருத்துவமனை எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை என உறுதி செய்கிறேன்.
மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.
செவிலியர் கையொப்பம் தேதி 12 01 202 பி எனது/உறவினர்/காப்பாளர் கையொப்பம் Signature of Admitting Nurse Date 01 16 RM - Signature of the Patient / Relative / Gurdian

ஊற்வமுகைற்

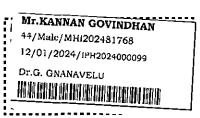
Nature of Relationship



discharge.









GENERAL CONSENT FOR ADMISSION

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

tariff. I have been informed and I understand that there can be usage of certain reprocessed items during the course of the treatment. I also understand that only full strips of medicines shall be issued and returned. I declare that I take full responsibility of settling the bill before leaving the hospital premises at the time of

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

Viu 📸 sam	Signature / Thumb Impression*	Name .	Date	Time	
Patient			12/01/24	01-16	
Surrogate/Guardian (if applicable #)	\$8.	(Write name and relationship with patient)	12/1/24	01.16] -
Reason for surrogate consent	Patient is unable to give consent I	Decause:			. ř
Witness			12 1/24	01.16	þm
Interpreter (if applicable)					

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







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

DISCHARGE SUMMARY

IP No.

IPH2024000099

D.O.A

: 12/01/2024

UHID

MHI202381768

D.O.P

: 12/01/2024

Name

Mr. KANNAN GOVINDHAN

Room No. : 110

Age / Gender

Consultant

44Years / MALE

: Dr. G. Gnanavelu. MD., DM., (cardio) FACC

D.O.D

: 14/01/2024

Chief Cardiologist

DIAGNOSIS:

CAD - EVOLVED IWMI

CAG - DOUBLE VESSEL DISEASE OF LCX & LAD (09.01.2024)

MILD LV DYSFUNCTION

SYSTEMIC HYPERTENSIÓN

PROCEDURE:

SUCCESSFUL PTCA + STENT TO DISTAL LCX DONE USING 2.5 X 22 MM ONYX TRUCOR DES & PROXIMAL LCX USING 2.5 X12MM ONYX TRUCOR DES & PTCA + STENT TO LAD DONE USING 2.25 X18 MM ONYX TRUCOR DES DONE ON 12.01.2024.

BRIEF HISTORY:

Mr. Kannan Govindhan, 44 years old male, presented with complaints of compressive type chest pain radiating to left arm. He was evaluated in Govt Stanley hospital, diagnosed as ACS - evolved IWMI on)4.01.2024 and advised Coronary angiogram which revealed **DOUBLE VESSEL DISEASE OF LCX & LAD** on 09.01.2024 and further advised for PTCA to LCX. He came to Medway heart institute for PTCA for which he has been admitted.

No H/O fever, vomiting, diarrhea.

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

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

PICCLE NIL

HR 84bpm

BP 130/80 mmHg

SPO₂ 96% in room air **CVS** S1S2 (+)

BAE (+) Abdomen Soft

#9, 1ສt Main Road, United ໃຫ້ຢູ່ໃຊ້ ເວັນໄອກy, Kodambakkam, Chennai - 600024. Tel : 044 - 4310 8959

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(i) @medwayhospitals

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94557 94557 1800 572 3003

Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

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

RS

Chengalpattu

Villupuram

Kumbakonam

Kakinada

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

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





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INVESTIGATIONS:

BLOOD: Hb- 14.6gm/dl, TWBC – 12380cells /cumm, PLT – 292000cells/cumm, Urea – 26mg/dl, Creatinine – 0.76mg/dl, Sodium – 139mg/dl, Potassium – 4.35 mg/dl.

ECG: sinus rhythm, HR – 84 bpm, evolved IWMI changes.

ECHO(12.01.2024): Mild concentric LVH. All chambers normal sized. RWMA (+)basal and mid infero septum, mid infero lateral, apical lateral hypokinetic. Mild LV systolic dysfunction, EF - 45%. Grade I diastolic dysfunction. Normal RV systolic function. IAS /IVS intact. All valves are structurally normal. Trivial MR. Trivial TR, No PAH. IVC normal in size and collapsing. Trace pericardial effusion postero lateral to LV, Behind RA. No clot / vegetation / pleural effusion.

UHID: MHI202381768

POST PCI INVESTIGATIONS:

BLOOD(13.01.2024):

Test Name	Result	Reference Value	Units
UREA	29	14 - 40	mg/dl
CREATININE	0.89	Male: 0.7 - 1.2	mg/dl
	,	Female: 0.5 - 1.0	
		Child: 0.2 - 0.8	

 $\underline{\mathbf{ECG}}$: sinus rhythm, HR – 79 bpm, no fresh ST-T changes

SCREENING ECHO(13.01.2024): S/P PTCA. No pericardial / pleural effusion. RWMA - basal & mid inferior, basal infero - septum hypokinesia. Mild LV systolic dysfunction. EF - 45%. Normal RV systolic function. All valves are normal. IAS / IVS intact. Trivial MR. Trivial TR. No PAH. No clot / vegetation.

COURSE IN THE HOSPITAL:

Mr. Kannan Govindhan, 44 years old male, admitted with above mentioned complaints. Basic nvestigation was done. After obtaining consent, he underwent SUCCESSFUL PTCA + STENT TO DISTAL LCX DONE USING 2.5 X 22 MM ONYX TRUCOR DES & PROXIMAL LCX USING 2.5 X12MM ONYX TRUCOR DES & PTCA + STENT TO LAD DONE USING 2.25 X18 MM ONYX TRUCOR DES DONE ON 12.01.2024 by Right radial artery approach. Post procedure was uneventful and shifted to CCU. Post procedure ECG shown no fresh ischemic changes. He was treated with dual anti-platelets, statin, nitrates, beta blockers and other supportive measures. His general condition improved. He got shifted to ward, RFT within normal limits, maintained adequate fluid balance. His medications are optimized and he is being discharged in a stable clinical condition.

CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile

General condition Stable

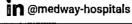
GCS 15/15

98.6°F BP Temp 130/80mmHg 96% in room a 80/min

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

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Medway Group of Hospitals Medway Centre of Excellence (Chennai) Kakinada **Heart Institute** Chengalpattu Villupuram Institute of Pulmonology Kodambakkam Mogappair Kumbakonam 044-2473 4455 | 044-26530011 | 044-27426829 | 04146-242000 | 044-2473 4455 | 0884-2333367 044 - 4310 8959 044-2473 4451 E-mail: info@medwayhospitals.com | Website: www.medwayhospitals.com | CIN: U74900TN2011PTC083665



UHID: MHI202381768



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ADVICE MEDICATIONS:

ACCREDITED NABH ACCREDITED

SI.	NAME OF THE DRUGS WITH	DOSAGE	FRE	QUEN	CY	ROUTE	RELATION	DURATION
NO	GENERIC NAME		M	A	N		SHIP WITH MEAL	
1.	TAB. ECOSPRIN (ASPIRIN)	75 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2.	TAB. AXCER (TICAGRELOR)	90 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
3.	TAB. AZTOR (ATORVASTATIN)	80 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4.	TAB. MET XL (METOPROLOL)	25 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
5.	TAB. NITROCONTIN (NITROGLYCERIN)	2.6 MG	I	0	1	ORAL	AFTER FOOD	TO CONTINUE
6.	TAB. FLAVEDON MR (TRIMETAZIDINE)	35 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
7.	TAB. ALPRAX (ALPRAZOLAM)	0.5 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
8.	TAB. VALENT (VALSARTAN)	40 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
9	TAB. PERINORM (METOCLOPRAMIDE)	10 MG	1/2	0	1/2	ORAL	AFTER FOOD	X 1WEEK
10	TAB. NIKORAN (NIKORANDIAL)	5 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
11	TAB. PAN (PANTAPRAZOLE)	40 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
12.	SYP. CREMAFFIN (LIQUID PARAFFIN)	15 ML	0	0	1	ORAL	AFTER FOOD	TO CONTINUE

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

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

W. Kovisha Content of the K. Kovisha The Content of the Content of the Content of the Cardiologist Chief Cardiologist

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

Reg. No: 39469

· (V

CONSULTANT SIGNATURE

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

Typed by: Ezhilarasi.

MedwayHospitals

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

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 Kumbakonam 044-23333367
 Kakinada 044-4310 8959
 Heart Institute of Pulmonology 044-2473 4451

MHI/HOSP/2022/118

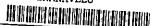




Mr.KANNAN GOVINDHAN

44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





INPATIENT INITIAL ASSESSMENT

Date: 12 1 74 Time of arrival in ward: 2 100
Allergies (if Yes, specify details):
Drugs
Blood Transfusion
Food
Others
Vital Signs: Temp: 98.6(°F) Pulse / HR: 84 (beats/min) BP: 180 8) (mmHg) Respiration: 18 (breaths/min) SpO2.76 (%) Height: 160 (cms) Weight: 65.5 (kgs) BMI: 23.6 7/m²
Pain: Yes No. If Yes, Score: HID Pain Scale Used: Numerical Rating Scale (>12 years) CPOT (ventilator / comatose) Duration: Location: Location: Burning Referred / Radiant Pain
CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS # 4 Try m came with HID chest Pain on & obox Iday HID usmitting sepisals since yesterday musting patient was apparently number before Iday, then he developed undertrain which is intermittent innetture associated with giddness. HID usmitting 3 episodes Upmittes contain 400d particles associated with mild giddness. Then he went reach hospital & CADT was done on oq. 1.24 else where now, he got admitted for further landuation PAST MEDICAL HISTORY (with duration of illness): Diabetes Mellitus: Yes INO. If Yes, duration: Hypertension: ITYES INO. If Yes, duration: Others:
Past Surgical History: H/O CAGH done on 09.1.24 showed Double West distance of LCX & LAD.

	ent Medication (for Med		uation):			, , ,
S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued durin
					٠	☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
			X			∵ ☐ Yes ☐ No
						☐ Yes ☐ No
		lis				☐ Yes ☐ No
		/ _			*	☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
				٠		☐ Yes ☐ No
	<i>i</i>	,				
	<u> </u>	1				
Perso Lifest	onal / Social History (Ti tyle: □ Sedentary □	ck whichever is	applicable)	· · · · · ·		i, i
Lifesi Smol	tyle: □ Sedentary □ king: □ Yes □ No	Active Occi	ipation:	Recreational	•	™o
Lifest Smok Other	tyle: Sedentary Sing: Yes No	Active Occi	ipation:	Recreational]No
Lifest Smok Other	tyle: Sedentary Sing: Yes No	Active Occi	ipation:	Recreational		ĪNo .
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Lifesi Smok Other Iensti	tyle: Sedentary king: Yes No rs: rual and Obstetric Hist eral Physical Exam	Active Occi	up for fema	Recreational		ĪNo .
Smok Other Hensti	eral Physical Exam	Active Occi Alcohol: Yes ory (to be filled ination: lcterus:	up for fema	Recreational	Clubbing: ☐ Ye	TNo .
Smok Other Menstri	tyle: Sedentary king: Yes No rs: rual and Obstetric Hist eral Physical Exam	Active Occi Alcohol: Yes ory (to be filled ination: lcterus:	up for fema	Recreational		TNo.

-	SYSTEMIC EXAMINATION
-	cvs: 5152 P
ĩ	Respiratory System:
	BA€ €
	Gastrointestinal System:
	Soft, non-tender
	Central Nervous System: NFND GCS - 15/15
]	Urinary / Reproductive / Locomotor System:
]	noomal
	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 - DVD Recently Aslas ATTN ACS - EWINED I STEME Mild Ly dustantion EF - 451.
	Plan of Care: Admit & Dr. ananguel - Pasts For Passation
	- NPO From 8 am tomossow - Shift to Couthfabon a
	- consent

Investigations Ac	dvised:			=			
	CBC, RBS, W	o, Co, No	at, pt		•	, ,	
	,						
				,			
			<u>-</u>				
Diet Advice:	_						
☐ Nil per Oral	Clear liquid diet	Normal liqui			liquid diet		
Semisolid diet	☐ Soft solid diet		n normal diet	☐ North Inc	lian normal d	liet	
Neutropenic liquid	diet Others: 19080	to remact	·				
Early Discharge Plan	nning (fill in those which are	appröpriate at thi	s stage):	PFE: Pa	tient Family L	Education (
Special support need	ded at home	☐ Yes ☐ No	If Yes, PF	E done			
Home equipment ant	ticipated	☐ Yes ☑ No	If Yes, PFI	done and equ	ipment advis	sed	
Physiotherapy at hon	ne anticipated	☐ Yes ☐ No If Yes, educated on physical limitations, if any					
Wound care needs a	nticipated at home	☐ Yes ☐ No If Yes, educated on signs on infection					
Pain Management		☐ Yes ☐ No If Yes, PFE done and medication advised					
Special Dietary need	s	☐ Yes ☐ No If Yes, educated on dietary restrictions, food drug interactions and allergies					
Continuous / ongoing	g care anticipated	If Yes, educated on various aspects of ongoing care required					
Other special educati	ion need, i.e.:	☐ Yes 🕒 No	If Yes, PF	E done		· ·	
Nature of post hospit infection control, fall	☐ Yes ☐ No	If Yes, spe	ecific education	given			
Others:	•			Ł			
	; 						
		•			•		
	,						
	Signature	Name		Reg. No.	Date	Time	
Resident Doctor	K'D TRUDTO	DR-ANUS	LUYA .	13477	12.1.24	. 9720	
Consultant	Stor	Dr Linano	7	39469	13/1124	09:45	
Patient Attendant	d. Jule	Relationship K.	Saryon		12/124	الحديد و	

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F Mr.KANNAN GOVINDHAN

1 44/Malc/MH1202481768

L 12/01/2024/IPH2024000099

Dr.G. GNANAVELU

C



CONSENT FORM FOR CRITICAL CARE (ICU)

I, Mr. kunnan Cto vin differ Patient or Representative of patient have (please tick the correct option
above and below):
Read
I have been explained in detail by the treating doctor and I understand about the condition of me / and my patient or my patient's illness and I am aware of the all the possible outcomes.
Been explained this consent form in English /, which I fully understand and understood the information provided about ICU Treatment
I acknowledge that, I had the opportunity to discuss with the doctor about the condition of myself or my patient, treatment options, procedures needed to improve the patient's condition. I hereby give consent to treat the illness of myself or my patient and to do emergency procedures like Endotracheal Intubation including other methods of securing airway, mechanical ventilation, central venous access, arterial lines and further methods of monitoring which are needed to improve or treat my condition.

CENTRAL VENOUS CATHETER INSERTION

Brief description of the Procedure:

A Central venous catheter or central line is a long, soft, thin, hollow tube placed into a large vein (blood vessel). Compared to a peripheral line, central line is larger, longer and is placed into a large vein in the neck, upper chest or groin.

Intended benefits:

Common reasons for having a central line include:

- To give IV medications over a long period of time because a large vein can tolerate an IV catheter for a longer time than a small vein. Examples of such medications are antibiotics and chemotherapy.
- · To rapidly deliver large amounts of fluid or blood, for example when a person is in shock.
- To give multiple drug infusions in critically ill patients
- To directly measure blood pressure in a large or central vein. This can help determine how much fluid a person needs.
- For patients who require frequent blood draws to be sent to the laboratory, the central line allows for blood to be drawn without repeatedly
 pricking the patient.
- To deliver nutrition directly into the blood when food or liquids cannot be given through the mouth, stomach, or intestine.
- To give vasopressors (Blood pressure increasing drugs) for a patient in shock, as giving vasopressors through peripheral line can cause injury to the small blood vessels.
- In some cases, two of the lumens on the central line can be used to perform dialysis, with one lumen used to take blood out of the vascular system and another lumen used to return the dialyzed blood to the body.

Possible risks and complications:

- Discomfort during placement: Discomfort can result from the needle stick and placement of the catheter at the time it is inserted.
- Bleeding: Bleeding can occur at the time the catheter is inserted. The bleeding is usually mild and stops by itself
- Infection: Any tube (catheter) entering the body can make it easier for bacteria from the skin to get into the bloodstream. Special care in cleaning and bandaging the skin at the catheter site can decrease the risk of infection.
- Thrombosis
- Arrythmia
- Pneumothorax (Collapsed lung): When a central venous catheter is placed in the chest area, if the needle passes through or misses the
 vein, the needle could pierce the lung causing the lung to collapse. If this happens, lung will be reflated by placing a tube between the ribs to
 remove the air that has leaked from the lung.

I have been explained the implications of not undergoing this procedure like:

- Worsening of clinical condition of the patient.
- · Repeated pricking for blood samples.
- Difficulty in getting peripheral venous access.
- When high dose vasopressors are needed, ischemia to the distal part of the limb.

Alternative Forms of Treatment: Peripheral Venous Access

ENDOTRACHEAL INTUBATION

Brief description of the Procedure:

Endotracheal Intubation is often an emergency procedure that's performed on people who are unconscious or who can't breathe on their own. Endotracheal Intubation maintains an open airway and helps prevent suffocation. A flexible plastic tube is placed into your / your patient's trachea through the mouth to help you breathe. The trachea, also known as the windpipe, is a tube that carries oxygen to the lungs.

The size of the breathing tube is matched to the age and throat size. The tube is kept in place by a small cuff of air that inflates around the tube after it is inserted. The trachea begins just below the larynx, or voice box, and extends down behind the breastbone, or sternum. Trachea then divides and becomes two smaller tubes: the right and left main bronchi. Each tube connects to one of the lungs. The bronchi then continue to divide into smaller and smaller air passages within the lung. The trachea is made up of tough cartilage, muscle, and connective tissue. Its lining is composed of smooth tissue. Each time you / your patient breathes in, the windcipe gets slightly longer and wider. It returns to its relaxed size as you breathe out. You can have difficulty breathing or may not be able to breathe at all if any path along the airway is blocked or damaged. This is when Endotracheal Intubation can be necessary. Endotracheal Intubation keeps your airway open. This allows oxygen to pass freely to and from your lungs as you breathe.

Intended benefits:

The procedure might be needed for you / your patient for any of the following reasons:

- to open airways so that patient can receive anaesthesia, medication, or oxygen
- to protect your / your patient's lungs
- when patient has stopped breathing or is having difficulty breathing
- when patient needs help to breathe
- when patient has a head injury and cannot breathe on his / her own
- when patient needs to be sedated for a period of time in order to recover from a serious injury or illness

Possible risks and complications:

- Injury to teeth or dental work
- Injury to the throat or trachea
- Bleeding
- Lung complications or injury
- Aspiration (stomach contents and acids that end up in the lungs)
- Other Risks (if any):

Possible alternatives:

Non invasive ventilation can be helpful in a few situations. But when Endotracheal Intubation is required, there can be no alternative treatment offered.

I am now aware of the intended benefits, possible risks and complications, and available alternatives to the said procedure. I am also aware that results of any procedure can vary from patient to patient; and I declare that no guarantees have been made to me regarding success of this procedure. I am aware that while majority of patients have an uneventful prosedure and recovery, few cases may be associated with complications. I am aware of the common risks and complications associated with this procedure as listed above, and understand that it is not possible to list all possible risks and complications of any procedure.

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

I, the above-named Patient / named patient's representative, do further hereby declare that I am above 18 years of age as on the date of signing this form, mentally sound and am giving consent without any fear, threat or false misconception.

	Signature / Thumb Impression*	Name	Date	Time
Patient				
Surrogate/Guardian (if applicable #)	Rug ~	(Write name and relationship with pa	RoTHE 12 1 2 V	16:00
Reason for surrogate consent	Patient is unable to give consent because:			
Witness	S. S.)	SHYAM	12/1/2	4 16 :00
Interpreter (if applicable)				

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

	Signature	Name	Reg. No.	Date	Time
Doctor		Doch Abolin	appro .	12/1/24	14 100



Patient Details (A	Affix Label here)
Name:	
UHID:	
DOB:	Sex:
DOA:	
Consultant:	



உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

		என்ற	பெயர் கொ	ாண்ட ⊐ நோ	யாளியா	ன அல்	லது 🛭	2 நோயாளியின்	பிரதிநிதி	யான		
	நான்,	இந்த	ஒத்திசைவு	படிவத்தை	(மேலே	ឃុំប្រញ់ល	கழே	உள்ளவற்றில்	சரியான	விருப்பத்தேர்வை	தயவுசெய்து	டிக்
செய்க)												

🗆 வாசித்திருக்கிறேன்

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

ு நான் முழுமையாகப் புரிந்து கொள்கின்ற தமிழ் மொழியில் இந்த ஒப்புதல் படிவம் விளக்கப்பட்டிருக்கிறது மற்றும் ஐசியு சிகிச்சை பற்றி தரப்பட்ட தகவலை நான் புரிந்து கொண்டிருக்கிறேன்.

எனது அல்லது எனது நோயாளியின் உடல்நிலை, சிகிச்சை விருப்பத்தேர்வுகள், நோயாளியின் நிலையை மேம்படுத்துவதற்கு தேவைப்படும் மருத்துவ சேவைகள் பற்றி மருத்துவரிடம் விவாதிக்க எனக்கு வாய்ப்பிருந்தது என்று நான் உறுதியளிக்கிறேன். எனது / எனது நோயாளியின் நோய்க்கு சிகிச்சையளிக்கவும் சுவாசப்பாதையை பாதுகாக்க / உருவாக்குவதற்கான பிற வழிமுறையை செயற்கை சுவாச வழிமுறை, மத்திய சிரை அணுகுவசதி இதய தமனி தமனிக்குழல்கள் உட்பட மூச்சுப் பெருங்குழலுக்குள் குழாய் செருகுதல் போன்ற அவசரநிலை மருத்துவ செயல்முறைகளை செய்யவும் இதன்வழியாக நான் ஒப்புதல் அளிக்கிறேன். மேலும் எனது நிலைமைக்கு சிகிச்சையளிக்க அல்லது அதனை மேம்படுத்த தேவைப்படும் கண்காணிப்பு வழிமுறைகளை மேற்கொள்ளவும் ஒப்புதல் அளிக்கிறேன்.

மைய சிரையில் கதீட்டர் உட்செருகல்

மருத்துவ செயல்முறையின் சுருக்க விவரணை:

ஒரு மைய சிரை கதீட்டர் அல்லது மைய லைன் என்பது, ஒரு நீளமான, மென்மையான, மெல்லிய, துவாரமுள்ள குழாய் ஒரு பெரிய நாளத்திற்குள் (இரத்த நாளத்திற்குள்) செலுத்தப்படக்கூடியதாகும். மையத்திற்கு அப்பாலுள்ள புற லைனோடு ஒப்பிடுகையில், மைய லைன் என்பது பெரியது மற்றும் நீளமானது; கழுத்து, மேற்புற மார்பு அல்லது இடுப்பு கவட்டையில் உள்ள பெரிய நாளத்திற்குள் வைக்கப்படுவதற்குரியது.

அடைய திட்டமிடப்படும் பலன்கள்:

மைய லைனை பொருத்துவதற்கான பொது காரணங்களுள் கீழ்க்கண்டவை உள்ளடங்கும்:

- ஒரு சிறிய நாளத்தைவிட, ஒரு பெரிய நாளமானது நீண்ட காலஅளவிற்கு ஒரு IV கதீட்டரை தாங்கும் என்பதால், நீண்ட காலஅளவிற்கு IV மருந்துகளை வழங்குவதற்காக. ஆன்ட்டிப்பாட்டிக் மருந்துகள் மற்றும் கீமோதெர்பி போன்றவை இதற்கான மருந்துகளின் எடுத்துக்காட்டுகளாகும்.
- அதிக அளவிற்கு திரவம் அல்லது இரத்தத்தை அதிவேகமாக வழங்குவதற்கு; எடுத்துக்காட்டாக ஒரு நபர் அதிர்ச்சியில் ஆழ்ந்திருக்கும்போது.
- உயிருக்கு ஆபத்தான நிலையிலுள்ள நோயாளிகளுக்கு ஒன்றுக்கு மேற்பட்ட பல மருந்து உட்செலுத்தல்களை வழங்குவதற்கு.
- ஒரு பெரிய அல்லது மைய சிரை / நாளத்தில் நேரடியாக இரத்தஅழுத்தத்தை அளவிடுவதற்கு. ஒரு நபருக்கு எந்தஅளவு திரவம் தேவைப்படுகிறது என்பதை தீர்மானிக்க இது உதவக்கூடும்.
- பரிசோதனையகத்திற்கு அடிக்கடி இரத்த மாதிரிகளை அனுப்ப வேண்டிய தேவையுள்ள நோயாளிகளுக்கு திரும்பத்திரும்ப நோயாளிக்கு
 ஊசிகுத்தி இரத்தம் எடுப்பதற்கு பதிலாக, எளிதாக இரத்தம் எடுக்க மைய லைன் வகை செய்கிறது.
- வாய், வயிறு அல்லது குடல் வழியாக தர இயலாதபோது ஊட்டச்சத்துகளை நேரடியாக இரத்தத்திற்குள் கலக்குமாறு வழங்குவதற்கு.
- பறவெளி லைன் வழியாக வாசோபிரெசர்ஸ் ஐ வழங்குவது சிறிய இரத்த நாளங்களுக்கு சேதத்தை விளைவிக்கும் என்பதால்,
 அதிர்ச்சியில் ஆழ்ந்துள்ள ஒரு நோயாளிக்கு வாசோபிரேசர்ஸ்களை (இரத்த அழுத்தத்தை அதிகரிப்பதற்கான மருந்துகள்) வழங்குவதற்கு.
- சில நேர்வுகளில், டயலாலிசிஸ் செய்வதற்கு மைய லைன் மீது இரண்டு குழல்களைப் பயன்படுத்தலாம். இரத்தநாள அமைப்பிலிருந்து இரத்தத்தை எடுப்பதற்கு ஒரு குழலையும், டயலாசிஸ் செய்யப்பட்ட இரத்தத்தை உடலுக்கு திரும்ப அனுப்புவதற்கு மற்றொரு குழலையும் பயன்படுத்தலாம்.

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

- பொருத்தப்படும்போது அசௌகரியம்: ஊசியால் குத்தும்போது மற்றும் கதீட்டரைப் பொருத்தும் நேரத்தில் அதனை உட்செலுத்துகின்ற நேரத்தில் அசௌகரியம் ஏற்படக்கூடும்.
- இரத்தக்கசிவு: கதீட்டர் உட்செலுத்தப்படும் நேரத்தில் இரத்தக்கசிவு நிகழக்கூடும். இந்த இரத்தக்கசிவு வழக்கமாக மிகச்சிறிய அளவில் லேசாக இருக்கும் மற்றும் அது தானாகவே நின்றுவிடும்.
- தொற்று: உடலுக்குள் நுழைக்கப்படும் எந்தவொரு குழாயும் (கதீட்டர்), சருமத்திலிருந்து பாக்டீரியா இரத்த ஓட்டத்திற்குள் கலப்பதற்கு
 இதனை எளிதானதாக ஆக்கிவீடும். கதீட்டர் பொருத்தப்படும் இடத்தை தூய்மைப்படுத்துவது மற்றும் பேண்டேஜ் செய்வதில் சிறப்பு கவனம்
 செலுத்தப்படுவது தொற்றுக்கான இடர்வாய்ப்பைக் குறைக்கக்கூடும்.
- இரத்தஉரைவு
- ஒழுங்கற்ற இதயத்துடிப்பு
- நுணையீரல் உறைக்காற்று நோய் (நுரையீரல் துவண்டு மடிதல்): மார்பு பகுதியில் ஒரு மைய சிரைகதீட்டர் பொருத்தப்படும்போது ஊசி சிரை / நாளத்தின் வழியாக கடந்து செல்லுமானால் அல்லது அதை தவறவிடுமானால் அந்த ஊசி நுரையீரலுக்குள் ஊடுருவி, நுரையீரல் துவண்டு மடிவதை விளைவிக்கும். இது நிகழுமானால், நுரையீரலிலிருந்து வெளியே கசிந்திருக்கின்ற காற்றை அகற்றுவதற்கு விலாக்களுக்கு இடையே ஒரு குழாயை வைப்பதன் மூலம் நுரையீரல் மீண்டும் மீட்பு வீக்கம் பெறுமாறு செய்யப்படும்.

இந்த மருத்துவ செயல்முறையை மேற்கொள்ளவில்லை எனில், கீழ்க்கண்டவை போன்ற விளைவுகள் நிகழலாம் என்று எனக்கு விளக்கிக் கூறப்பட்டிருக்கின்றன:

- நோயாளியின் மருத்துவ / உடல்நிலை மோசமடைதல்.
- இரத்த மாதிரிகளுக்காக திரும்பத்திரும்ப ஊசி குத்துவது.
- புறவெளி இரத்தநாள அணுகுவசதியை பெறுவதில் சிரமம்.
- அதிக அளவிலான வாசோபிரெசஸர்ஸ் தேவைப்படும்போது உறுப்பின் தொலைதூரப் பகுதிக்கு இரத்தலுட்டத்தடை

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அணுகுவசதி

முச்சுப் பெருங்குழலுள் குழாய் செருகுதல்

மருத்துவ செயல்முறையின் சுருக்கமான விவரணை:

முக்கப் பெருங்குழலுள் குழாய் செருகுதல் (Endotracheal Intubation) என்பது, தாங்களே கயமாக கவாசிக்க இயலாத அல்லது நினைவிழந்துவிட்ட நபர்களுக்கு செய்யப்படும் ஒரு அவசரநினை சிக்சை செயல்முறையாகும். இது, ஒரு திறந்தநிலை முக்கப்பாதையை பராமரிக்க வகை செய்கிறது மற்றும் முக்கத்தின்றல் நிகழாமல் தடுக்கிறது. நீங்கள் சுவாசிப்பதற்கு உதல, உங்களது / உங்களது நோயாளியின் மூச்சுக்குழலுக்குள் ஒரு நெகிழ்வுத்திறன் கொண்ட பிளாஸ்டிக் குழாய் வாய் வழியாகப் பொருத்தப்படுகிறது. முச்சுக்குழறும் அழைக்கப்படுகின்ற இந்த மூச்சுக்குழல், ஆக்சிஜனை நுறையீரல்களுக்கு எடுத்துச்செல்லும் ஒரு குழாயாகும். கவாசிப்பதற்கான இந்த குழாயின் அளவு நோயாளியின் வயது மற்றும் தொண்டை அளவிற்குப் பொருத்தமானதாக தேர்வு செய்யப்படும். உட்செலுத்தப்பட்டதற்குப் பிறகு குழாயை சுற்றி விரிவடைகின்ற காற்றின் ஒரு சிறிய சுற்றுப்பட்டையின் மூலம் உட்செலுத்துத்பபட்ட குழாய் அதே இடத்தில் இருக்குமாறு வைக்கப்படும், முச்சுக்குழாய், குரல்வலைக்கு சற்றுகிழே தொடங்குளிது மற்றும் மார்பு எலும்பிற்கு பின்னே வரை அது நீள்கிறது. அதன்பிறகு மூச்சுக்குமாய் இரு சிறு குழல்களாக பிரிகிறது: வலது மற்றும் இடது பிரதான மூச்சு சிறுகுழாய், அவ்வொரு மூச்சுக்குழாயி, அவ்வொரு இணைக்கப்பட்டிருக்கிறது. இந்த முச்சு சிறுகுழாய், அதன்பிறது உருவானது. இதன் அகவுறை மீருதுவான திசுக்களால் ஆனது, ஒவ்வொரு மூச்சுக்குழாய் என்பது, கடினமான குருத்துதலும்பு, தசை மற்றும் இணைப்புத்திக ஆகியவற்றால் உருவானது. இதன் அகவுறை மீருதுவான திசுக்களால் ஆனது, ஒவ்வொரு மூசையும் விடும்போது அதன் முந்தைய தளர்வான நிலைக்கு அது திரும்புகிறது. முச்சுப்பாதையில் எந்தவொரு இடமும் சேதமடைந்திருக்குமானால் அல்லது தடை பட்டிருக்குமானால் உங்களால் சுவர்கிக்க இயலாமல் போகலாம் அல்லது சுவாசிப்பதில் சிரமம் இதக்கலாம். இத்தகைய தருகைந்தில் தான் முச்சுப் பெருங்குழலுள் குழாய் செருதுதல் அவசியமாக இருக்கக்குமும் நுறையில் கைக்கிறது. மீச்சு / காற்றுப்பாதைகை அது அனும்கிறது. நீங்கள் சுவாசிக்கும்போது உங்களது நுறுப்பாகை இதன்று மற்றும் நுரையில் கைக்கிறது. நீங்கள் சுவாசிக்கும்போது உங்களது நுறுப்பாதைக்குறது.

அடையத் திட்டமிடப்பட்டுள்ள பலன்கள்:

கீழ்வரும் ஏதாவதொரு காரணத்திற்காக இந்த மருத்துவ செயல்முறை உங்களுக்கு / உங்களது நோயாளிக்குத் தேவைப்படக்கடும்:

- உணர்விழப்பு மருந்து, பிற மருந்துகள் அல்லது ஆக்சிஜன் போன்றவற்றைப் பெறுவதற்காக முச்சுப்பாதையை திறந்த நிலையில் வைப்பது.
- உங்களது /உங்களது நோயாளியின் நுரையீரலைப் பாதுகாப்பது சுவாசிக்க உதவ:
- சுவாசிப்பதை நோயாளி நிறுத்திவிட்டபோது அல்லது சுவாசிப்பதில் சிரமம் இருக்கும்போது
- சுவாசிப்பதற்கு நோயாளிக்கு உதவி தேவைப்படும்போது
- நோயாளிக்கு தலைக்காயம் ஏற்பட்டிருக்கும்போது மற்றும் தானாகவே அவரால் சுவாசிக்க இயலாதபோது
- ஒரு கடுமையான காயம் அல்லது நோயிலிருந்து மீண்டு வருவதற்காக நீண்ட காலஅளவிற்கு ஒரு நோயாளி உணர்விழப்பு மருந்தின் கீழ் அல்லது மயக்க நிலையின் கீழ் வைக்கப்படுவது அவசியமாக இருக்கும்போது.

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

- பற்கள் அல்லது பற்கட்டமைப்பிற்கு காயம்
- தொண்டை அல்லது மூச்சுக்குழாயில் காயம்
- இரத்தக்கசிவு
- நுரையீரல் சிக்கல்கள் அல்லது காயம்
- உறிஞ்சி வெளியிழுத்தல் (வயிற்றிலுள்ள உணவுப்பொருட்களும், அமிலங்களும் நுரையீரல்களில் சேர்ந்திருக்கும்போது)
- பிற இடர்கள் (ஏதும் இருக்குமாணல்):

சாத்தியமுள்ள மாற்று வழிமுறைகள்:

உடலுக்குள் ஊடுருவாத சுவாச ஏதுவாக்கல் முறையானது, சில குழ்நிலைகளில் உதவிகரமாக இருக்கக்கூடும். ஆனால், மூச்சுப் பெருங்குழலுள் குழாய் செருகுதல் அவசியப்படும்போது, வேறு மாற்று சிகிச்சை முறைகள் வழங்கப்படுவதற்கு வழியில்லை.

மேற்குறிப்பிடப்பட்ட மருத்துவ செயல்முறையின் மூலம் அடைய திட்டமிடப்பட்டுள்ள பலன்கள், சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள், இந்த செயல்முறைக்கு கிடைக்கக்கூடிய பிற மாற்று வழிமுறைகள் பற்றி இப்போது நான் அறிந்திருக்கிறேன். எந்தவொரு மருத்துவ செயல்முறையிலும் அதன் முடிவுகள் நோயாளிக்கு நோயாளி வேறுபடக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன்; மற்றும் இந்த மருத்துவ செயல்முறையின் வெற்றி குறித்து எனக்கு எந்தவித உத்தரவாதங்களும் அளிக்கப்படவில்லை என்பதையும் நான் உறுதிபட தெரிவித்துக்கொள்கிறேன். பெரும்பான்மையான நோயாளிகளுக்கு அசம்பாவிதம் இல்லாமல் அறுவைகிகிச்சை மற்றும் மீண்டு குணமடைதல் நிகழ்கின்ற நேற்வில், சில நேர்வுகளில் சிக்கல்கள் ஏற்படக்கூடும் என்பதையும் நான் அறிந்திருக்கிறேன். மேலே குறிப்பிடப்பட்டுள்ள இந்த மருத்துவ செயல்முறையோனு தொடர்புடைய பொதுவான இடர்கள் மற்றும் சிக்கல்களை நான் அறிந்திருக்கிறேன். எந்தவொரு மருத்துவ செயல்முறையிலும் ஏற்பட சாத்தியமுள்ள ஆபத்துகள் மற்றும் சிக்கல்கள் அனைத்தையும் பட்டியவிட சாத்தியமில்லை என்பதையும் நான் புரிந்துகொள்கிறேன்.

இந்த மருத்துவ செயல்முறையின் தன்மை மற்றும் சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள் மற்றும் உத்தேசிக்கப்படும் நன்மைகள் மற்றும் சாத்தியமுள்ள மாற்றுமுறைகள் பற்றி நான் அல்லது மேலே பெயர் குறிப்பிடப்பட்டுள்ள எனது நோயாளி முழுமையாக அறிந்திருக்கும் நிலையில் எனக்கு விளக்கப்பட்ட மேற்கண்ட மருத்துவ செயல்முறைக்கு சுயவிருப்பத்துடன் எனது ஒப்புதலை நான் அளிக்கிறேன்.

மேலே பெயர் குறிப்பிடப்பட்டுள்ள நோயாளியான / நோயாளியின் பிரதிநிதியான நான், இப்படிவத்தில் கையொப்பபிடும் தேதியில் 18 ஆண்டுகள் வயதுக்கு மேற்பட்ட, சீரான நல்ல மனநலம் கொண்ட நபராக இருக்கிறேன் மற்றும் எந்தவித அச்சம், அச்சுறுத்தல் அல்லது தவறான கண்ணோட்டம் இல்லாமல் இச்செயல்முறைக்கு வட்புகல் அவிக்கிறேன் என்று இதன் அலும் நான் பேலும் உறுகிறொழியனிக்கிறேன்.

	கைபொப்பம் / கட்டைவிரல் ரேகை*	பெயர்	தேதி	% Бую
நோயாளி				
பதிலாள் / பாதுகாவலர்	-		 	
(பொருந்துமாணல் [#])		(பேயர் & நோயாளிக்கு என்ன உறவுமுறை	1	
		என்பதை எழுதவும்)		
	நோயாளியால் ஒப்புதல் வழங்க இயலவில்) ග හ; ඉඛි <u>ක</u> න්නිණ:		
பதிலாள் ஒப்புதல்				
வழங்குவதற்கு காரணம்				
சாட்சி				
மொழிபெயர்ப்பாளர்				
(பொருந்துமானால்)				

^{*}ஆண்களுக்கு வலது பெருவிரல் மற்றும் பெண்களுக்கு இடது பெருவிரல் ரேகை பதிவு | # உரிய வயது வராதவராக அல்லது, ஒப்புதல் கொடுக்க இயலாதவராக தோயாளி இருந்தால் மட்டுமே.

கீழே, கையொப்பமிட்டுள்ள மருத்துவராகிய நான். திட்டமிடப்பட்ட ஆபரேஷன் / நடைமுறை குறித்த தன்மை, ஏற்பட சாத்தியமுள்ள ஆபத்துகள் மற்றும் சிக்கல்கள், கிடைக்கும்என்று கருதப்படும் நன்மைகள், எதிர்பார்க்கப்படும் நடைமுறைக்குப் பின் சிகிச்சை, மற்றும் சாத்தியமுள்ள மாற்று வழிமுறைகள் பற்றி நோயாளியிம் / நோயாளியின் பிரதிதிதியிடம் எடுத்துக்கூறி விளக்கியுள்ளேன். மேலும் அவர், இந்த ஆவணத்தில் விவரிக்கப்பட்டபடி, தகவலை முழுமையாக புரிந்துகொண்டுள்ளார் என்பதை நான் உறுதியாக நம்புகிறேன்.

	கையொப்பம்	டெயர்	பதிவு எண்.	தேதி	நேரம்
மருத்துவர்					





MHI/IP/2022/041

Medway
Heart
Institute
Every heart beat counts

	DOCTOR'S PROGRESS NOTES
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MHI/IP/2022/041 Medway Heart Every heart beat counts

	DOCTOR'S PROGRESS NOTES
DATE	NOTES
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Mr.KANNAN GOVINDHAN 44/Malc/MHI202481768

12/01/2024/IPH2024000099

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MHI/IP/2022/041

Dr.G. GNANAVELU

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DOCTOR'S PROGRESS NOTES				
DATE	NOTES			
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(A Unit of United Alliance Healthcare PVI Ltd)





Mr.KANNAN GOVINDHAN

44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





Date: 12 1 24

ICU PROGRESS NOTES

Time: 9pm

Doctor's Name: Dr. Vehrunyan P.

ICU SCORES

CLIF ACLF / AD score:

(as Appropriate)

SOFA score:

MELD score:

AARC score:

SAPS II score:

APACHE II score:

ICU Day - \ Background

> AU - DVD 40

Issues last 24 hours

Central nervous system

Conscious / oriented / sedated with

Sedation'score

GCS - E, V_M Pain score

Pupils

Drains

Cardiovascular system

HR - 86 m Rhythm - NJA Cardiac Output -

BP - 110/ FD CVP -Cardiac Medications:

Respiratory system

Oxygen supplementation – $\mathfrak{L}(\mathcal{L}^r)\mathcal{V}$

Saturation / PaO2-

Ventilator: Spontaneous / Controlled Last C x R -

Drains -

GIT

P/A Solf

Bowels - X/N Loose stools / Melena

Drains

NG tube: Y/N

Day NGA-

USG CT

Nutrition & Fluids

Oral feeds / NG feeds

TPN - formula used

Supplements

Calories / Proteins achieved:

IV fluids -

24 hour Urine output

Fluid balance

Creatinine clearance

Acidosis

Lactate

RRT - SLED / IHD / CRRT

Microbiology

Invasive lines

1. ONE M

2.

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N-Day

Culture reports

Antimicrobials with days

DVT prophylaxis, -- X/N/

Stress Ulcer Prophylaxis - Y/N

1.

2.

3.

Labs

Hb

Platelets

Creatinine

Urea

Κ

Bilirubin

AST

Drugs:

Mechanical - TEDS / SCD

Na

ALT

Drugs

Pressure sore Y / N

INR

Others

Alpha bed Y / N

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



Mr.KANNAN GOVINDHAN 44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





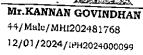
Time: 9,00	OGRESS NOTES
ICU SCORES CLIF ACLF / AD score: (as Appropriate) SOFA score:	MELD score: AARC score: SAPS II score: APACHE II score:
ICU Day Background Cto ACS TWO. POM PYCA	Issues last 24 hours
Central nervous system Conscious / oriented / sedated with Sedation score GCS - E V M V / (S Pupils B') Pain score Drains	Cardiovascular system HR - 名の Rhythm ハ Cardiac Output - BP - いかしゅの CVP - Cardiac Medications:
Respiratory system Oxygen supplementation – Saturation / PaO2- Ventilator: Spontaneous / Controlled Last C x R - Drains -	GIT P/A Boweis AN Loose stools / Melena Drains NG tube: Y / N Day NGA- USG CT
Nutrition & Fluids Oral feeds / NG feeds TPN – formula used Supplements Calories / Proteins achieved: IV fluids - 24 hour Urine output Fluid balance Creatinine clearance Acidosis Lactate RRT – SLED / IHD / CRRT	Microbiology Invasive lines 1. 2. Foley's Yes / No ET Tube / Tracheostomy tube - Y / N Day Culture reports Antimicrobials with days 1. 2. 3.
Labs Hb TC Platelets Urea Creatinine Na K Bilirubin AST ALT INR Others	DVT prophylaxis – Y/N Drugs: Mechanical – TEDS / SCD Stress Ulcer Prophylaxis + Y/N Drugs Pressure sore Y / N Alpha bed Y / N

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Dr.G. GNANAVELU



MHI/IP/2022/041 Medway Heart Institute

Every heart beat counts

	DOCTOR'S PROGRESS NOTES	ļ
DATE	NOTES	
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DO CHOP'S NOTES



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

MI.KANNAN GOVINDHAN 44/Malc/MHi202481768 12/01/2024/IPH2024000099

PRE/POST OPERATIVE ECHO

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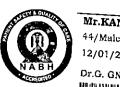
MI.KANNAN GOVINDHAN 44/Malc/MHI202481768 12/01/2024/IPH2024000099 Dr.G. GNANAVELU THE THE FERTINE ENGINEERING HEAVEN THE FIRST



	DOCTOR'S PROGRESS NOTES
DATE	NOTES
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MHI/IP/2022/041 Mr.KANNAN GOVINDHAN 44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU

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	DOCTOR'S PROGRESS NOTES
DATE	NOTES
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DATE	NOTES		
14/1/24	S/B Dr. Br. Lawshmi		
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	Inj. Para 19 1 V Stat given		
	O/E. Conscious		
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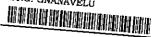


Every heart beat counts

Mr.KANNAN GOVINDHAN

44/Malc/MHI202481768 12/01/2024/IFH2024000099

Dr.G. GNANAVELU



DIABETIC CHART

ACTUAL WE	IGHT	65.5 /4 HbA,c		and a sect that \$14	A CHARLES AND
PREVIOUS I	DIABETIC I	MEDICATIONS			
DATE	TIME	BLOOD SUGAR	DIABETIC DRUG	Sign.	ENDORSED BY
12/1/24	ور و	112 myldl		De ohl.	14 My 15 59
	lb !0b	112 mg/dl	<u>-</u>	DUO	DR. POILA
13/1/27	1 80	121 nglot		owe	Bo. VELMURUGE
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•					

INSTRUCTIONS FOR INSULIN INFUSIONS

*	Mix 40u short acting Insulin in 40 ml. of	mg / dl	INSULIN INFUSION
*	normal Saline (IU - 1 ml.) Start Insulin Infusion 1-2 u / hr (1-2 ml / hr.).	< 100	Stop Infusion for 30 mins, recheck Glucose level, if B.S. is still <100 give Glucose and recheck B.S. every 30 mins, until the level is above 150. Then restart infusion with rate 1 u / hour.
*	Monitor Blood Glucose hourly (every 2nd hourly when stable) and adjust Insulin rate	150-200 201-250	Adjust Infusion rate to 2u / hr. Adjust Infusion rate to 4u / hr.
	according to the following Algorithm.	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

BLOOD	GROUP

INVESTIGATION SHEET

Mr. KANNAN GOVINDHAN

A 44/Malc/MHI202481768

U. 12/01/2024/IPH2024000099

DI Dr.G. GNANAVELU

						William Internation
Date	12/1/24	13/1/24.				
HAEMATOLOGY	-					
Hb	14.6					
P.C.V	43.3		-			
Platelets	29200					
TLC	12380					
Polymorphs	78.4					
Lymphocytes	15.9					
Eosinophils	1.2					
Mono / Basophils	4.2/0.1	_				
E.S.R						
BIO-CHEMISTRY	_					-
Urea	2-6	29.				
Creatinine	0.76	0.89.				
Sodium	139	0 0 0				
Potassium	4.35					
Bicarbonate						
Chloride						
Magnesium						•
Calcium						
Phosphorus	<u> </u>					
LFT						
T.Bilirubin						
D.Bilirubin						
I.Bilirubin						<u> </u>
S.G.O.T				-		
S.G.P.T						
ALP			_			
GGT			_			
Total Protien						
S.Albumin_			_	<u> </u>		
CARDIAC ENZYMES						
Troponin I					_	,
CKNAC - CPK					_	
CK - M.B. MASS						
LDH						
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LIPID PROFILE			_				1
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VLDV							1
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Medway Hospitals®

The way to better health (A Unit of United Alliance Healthcare Pvt Ltd) Mt.KANNAN GOVINDHAN

44/Male/MHI202481768

12/01/2024/IPH2024000099

Dr.G. GNANAVELU

Hoom,







Every heart beat counts

BLOOD GROUP

ON ADMISSION				
Height in CM	Weight in Kg.			
160cm	65-5 /29			

VITAL INFORMATION SHEET

Diagnosis: CAD- DODISH(al Procedure: 197CA TO LAO & LCX + CAG NO, OF DAYS BOA DA4-2 Jay-3 DATE 2 6 10 2 6 HOUR 40.5° 39⁰ 38.5 38 PULSE RESP B.P. SPO2 6545/49 **DAILY WEIGHT** 1200 ml 24 HRS INTAKE 24HRS OUTPUT 1650 mg 150 ml BALANCE MOTION







Every heart beat counts

EARLY WARNING SCORE MONITORING CHART

Name: _						Age	/Sex:				atient	10 140	:		_ -
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monitoring 3 Every 2nd Hourly 2 Every 4th Hourly

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44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU







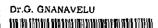


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Every heart beat counts

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44/Mule/MHI202481768 12/01/2024/IPH2024000099









Every heart beat counts **Date** From: 12/ To: /ይ Bed No: **INTAKE & OUTPUT** 24 Hrs: Started Time: Ended Time: 7-450 **CHART** NPO Started at: NPO Over at: SHIFT Morning **Afternoon Night** Restricted Fluid (RF) INTAKE 00 **OUTPUT** JC0 Difference: Total Intake: **Total Output:** INTAKE (ml) **OUTPUT (ml)** Intravenous Infusion Tube N/G Drain Endorsed Time Oral (Ord **Vomitus** Others Total R/N Sign Feeding Type of Fluid Time **Urine** Aspirate Tube Additions Amount by 8-00 100 9.5. 200 200 100 11-20250 D Apoln toom.





44/Male 202481768 12/01/2024/iPH2024000099

Dr.G. GNANAVELU





Date	Fre	om: 13/0/5	То	ः।भीवारि	ц. Ве	ed No: 🥎	0H .					INITA	VE 0		DUT
		tarted Time		_	Ended T	ime :	f;60	. <u>-</u>				INIA	KE &		PUI
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SHIF	r	N	lorning		After	noon			Nigh	t		Rest	ricted F	luid (R	F)
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Mr.KANNAN GOVINDHAY 44/Male/MH1202481 12/01/2024/IPH2024000099 Dr.G. GNANAVELU







Every heart beat counts From: 13/01/24 Bed No: 20473 To:1 A D Date **INTAKE & OUTPUT** Ended Time: 3.10 24 Hrs : Started Time : 700 **CHART** NPO Started at: NPO Over at: SHIFT Morning **Night** Restricted Fluid (RF) **Afternoon** 600 m INTAKE 850 ml **OUTPUT** 1650 ml 150 ml **Total Output:** 1200 m Difference: Total Intake: INTAKE (ml) OUTPUT (ml) Intravenous Infusion **Tube** ीर्ला N/G Drain Endorsed Total Time Orai **Others** Time Urine Vomitus R/N Sign Feeding Type of Fluid Aspirate Tube **Additions** by Amount Roo 8-80 D00 TOTA DVIUDRE MOTE boom 24.30 300 1100 90-30 200 800 2-30 250 1350 2.30 200 0001 1650 630 200 6-30 300 1200 1200 mg ENTRAKE M50 ml TMA 807 BALANCE









From: 14 01 24 To: INTAL Bed No: 21 Date **INTAKE & OUTPUT** ন-৩ **Ended Time:** 24 Hrs: Started Time: **CHART** NPO Started at: NPO Over at: **SHIFT** Afternoon Restricted Fluid (RF) Morning Night DISOMI INTAKE OUTPUT COM (**Total Output:** Difference: Total Intake: **INTAKE** (ml) **OUTPUT (ml)** Intravenous Infusion Tube N/G Drain Endorsed Time | Oral Kee ! Total. **Vomitus** Feeding Type of Fluid **Others** R/N Sign Time **Urine Additions** Aspirate Tube by Amount 7-10100 Zoo 17. Uo 1200 100 11-02 252 11.03820£ luchers ab





PRE/POST OPERATIVE ECHO

12/01/2024/IPH2024000	1 :
Dr.G. GNANAVELU	Caroning & day
Date & Time	Screening & cho
13 01 2024	SIP PTCA.
19:06 am 1	. No pericardial plaured effusion - Ruma - Basal & mid inferiors Basal infuo-septum hypokinelie
	- RUMA - Basal & mid inferior
	Basal inquo-septum hypokinelie
	- mid LV systolie dystanction
	- Mied LV Systolie dysfunction Normal RV Systolie dunction . All values are normal
	. All values are normal
	- 185/ 2NS intact
	Trivial HR:
	- Trivial TR. NO PAU
	- NO clot / vegetalión
	U
	WIDD: 48 TRPS: 10
	WIDS: 37 Rusp: 20
	ET: 45.7 EVA-, 1.26
<u> </u>	ET: 45.1 EM-: 1.26 Med ElE': 11-9.5 EDV: 104M LOT ELE': 8.57
	For: 104my lat ElE': 8.57
	EM: 52M
	EF: 49./,
	HR: 366pm
	Done by: Zibiay, (PA, RLS)
-	M41 (0053



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M41202281768

Every heart beat counts

Department of	of Dietetics
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NUTRITION ASSESSMENT AND CARE PLAN FORM

Patient Details (Artix Label here)
Mame: HR. KACKADI WAS
PPOOLY OUT HILL
DOB: Yugan Sex: HAVE
DOA: 12/1/24 Consultant: Dr. Granquero.

it	cms	KgsKgsKgs	Food allergie	s: Yes/ Norit yes, speci	ify	
)t:(60	'	<u> </u>				<u> </u>
ous Beliefs:		_ Vegetarlan	Non Vege		☐ Eggetarian	lain
rescription JECTIV	E GLOB	COLORIA LO	T (ABULTS)	> naut	Dulf In cott	Dethouses
	(A) -	Patient's related Medical His	•	<u> </u>		· · ·
	1)	Weight Change (overall chang	ge in past 6 months)	-		•
 !			□2 ·	□3 ₃	, 🗀 4	□ s
	1	No weight change/ gain	<5%	S - 10%	10 - 15%	>15%
2)	Dietary Intake	Duration:	Ľ,	_ - -	<u> </u>	
	1	9		3	D4	□5
	Grai	No change	Sub - optimal solid diet	Full liquid diet f moderate overall decrease	. Hypa-caloric liquid diet	Starvation
	Enteral / Parenteral Nutrition	Adequate / Excessive	Sub - optimal	Inadequate	Typo-caloric feeds	Starvation
3) '	Gastrointesti	nal Symptoms Duration:			<u> </u>	
٠,			<u> </u>	□ 3 • • • • • • • • • • • • • • • • • • •	□4	□ 5
	•	No symptoms	Nausea	Vomiting / : moderate GI symptoms	Diarritoea	severe anorexia
4)	Functional C	apacity (Nutrition related functional im	pairment) Duration:		<u> </u>	
		<u> </u>	□ 2	□3 ,	□4	□ s
		None /Improved	Difficulty with ambulation	Difficulty with normal activity	Light activity	Bed / chair - ridden with no or little activity
5)	Co - morbidity	(Olsease and its relationship to nutrition	on requirements)			1,1
	-	□ 1	□ 2	The state of the s	□4	<u> </u>
		Healthy	Mild co - morbidity	. Moderate co - morbidity/ agé >75 years	severe co - morbidity	Very severe multiple co - marbidity
B)	Physical exa	mination	• , , , , , , , , , , , , , , , , , , ,		·	
1)	Decreased fa	t stores or loss of subcutaneous fat	•	•	' 1	
		P 1	□ 2		0 4	□ s
		/		I -		
	-	Normal	Mild	Moderate		Severe
2)	Sign of muscle	Norma!	Mild		1	Severe
2)	Sign of muscle	Norma!	Mild		, , , , , , , , , , , , , , , , , , , ,	Severe
	Sign of muscle	Norma! wasting		Moderate	, .	· · · · · · · · · · · · · · · · · · ·
- - i	Sign of muscle	Normal Normal		Moderate 3 Moderate	, D4,	s
Total Score =		Normal wasting Normal ponents		Moderate 3 Moderate		s
; Total Score =	= Sum f above 7 com	Normal wasting Normal ponents	D 2 Mild	Moderate 3 Moderate		s
Total Score =	= Sum f above 7 com	Normal Normal Normal ponents	D 2 Mild	Moderate 3 Moderate		s
Total Score =	= Sum f above 7 com Status : Based on thir Well Nourished	Normal Normal Ponents s patient is	D 2 Mild	Moderate 3 Moderate		s
Total Score = Nutritional S Nutrition Inte	Sum f above 7 com Status : Based on this Well Nourished Moderately Ma Severely Malno	Normal Normal Ponents s patient is	D 2 Mild	Moderate 3		s
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12h/24, 1240 Maria Catherine John (177)

Senior Dietitian

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Mr. KANNAN GOVINDHAN
44/Malc/MHI202481768
12/01/2024/IPH2024000099
Dr.G. GNANAVELU



PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

	Diagnosis:	AD - DVD	1SHTNA	llergies if a	any: N	KDA-			
	From (Area)	To (Area)	Date	Time	Reason	for Transfer / Na	me of Pro	cedure	
	(ccv	Coethla	b 12/1/24	BE: 31		Acy_			
	Method of Transfer: ☐ On Bed ☐ On Wheelchair ☐ On Stretcher								
)	ASSESSMENT (General condition	OF PATIENT: on of Patient: Consc	ious 🗆 Semi-cons	scious 🗆 t	Jn-conscio	ous			
	Language Barrio	er: 🗌 Yes 🗗 No 🔲 If Ye	s, specify:						
J	Fall Risk Category: ☐ Low Risk ☐ Medium Risk ☐ High Risk								
	Vital Signs (to be documented at the time of shifting):								
	Temp (°F)	RR (breaths/min)	Pulse (beats/mir	' 	0, (%)	BP (mmHg)	Pain	Score	
	98.42	211	99 6/20	e 9'	74.	129/80	0		
	Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months) ☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years) ☐ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose) Any pre-medication given: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐								
	Any specific rec	ommendation:				-			
	Handover by	Signature	Name Nothy	Q _r	E	Emp. No.	Date	Time	
1	Handed over to		V-(2)	Binays		9202	14/24	17/4	
		eted: 🗆 Yes 🗀 Yes A		ion:		wî/			
		documented at the time		·	0 (0/)	/ DD (U-)	l n-t-	<u> </u>	
	Temp (°F)	RR (breaths/min)	Pulse (beats/mir	٠ ١ ۵	0, (%) () -/-	BP (mmHg)	 /	Score	
	☐ FLACC Scale	PIPPS (28 weeks to (2 months - 7 years)	≤ 38 weeks) □CF Wong-Baker FACE	RIES (38 we S Pain Rati	eks - 2 mo	•	s)		
	Handover by	Signature	Name	01/	E	mp. No.	Date,	Time	
	Handed over to		Math	ig a		0240	1211/24	6673	



MHI/CRD/2022/026

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Every heart heat counts

CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

	t CORONINI MINORE	
Mr.KANNAN GOVINDHAN		
T/ Maic/MHI202481760	ge:	Sex: M/F
12/01/2024/IPH2024000099		
Dr.G. GNANAVELLI	vard & Bed No:	UHID
	<u> </u>	

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

RISKS OF THIS PROCEDURE

The risk of coronary angiography depends on:

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

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

PATIENT CONSENT:

I REQUEST TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship				
witness	3/3	S. Saman (Boringe)	12/1/24	17:00
Doctor	(b) 93700	DR. KARTHI	12/1/26	1700
Interpreter			, , , , , , , , , , , , , , , , , , , ,	



MHI/CRD/2022/026...

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Heart
Institute

இருதய ஆன்ஜியோகிராம் பரிசோதனைக்கான ஒப்பம்

நோயானியின் பெயர்:	வயது:	பாலினம்: ஆண் / பெண்
மருத்துவ ஆலோசகர்:	வார்டு படுக்கை எண்:	யுஹெச்ജடி (UHID) :

நீலை மற்றும் செயல்முறை

பழைய இரும்புக் குழாய்களில் துருபிடிப்பதைப் போல். தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாரடைப்பினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிரை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியரேகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு லோக்கல் அன்ஸ்தீட்டிக் (மயக்க மருந்து) வழங்கப்பட்ட பின். ஒரு சிறிய குழாயானது (கதீட்டர்) கவட்டை/கையிலுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிரை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டுள்ளன கான்ட்ராஸ்ட் மீடியத்தினை (எண்ஸ்ரே டை) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுயக்க இருதய கீழறை) இந்த கான்ட்ராஸ்ட் மீடியம் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்ப் செய்கிறது என்பதை மதிப்படவும் மற்றும் அது எவ்வாறு பம்ப் செய்கிறது என்பதை மதிப்படவும் மற்றுகள்கள் நமக்கு இதயச்சுவர்சிரை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகீட்சையை மேற்கொள்ள முடியும். இவை பை-பாஸ் அறுவை சிகீட்சையாகவும் இருக்கலாம். அல்லது ஆன்ஜியோமினாண்டி (பனுன் வடிவம் கொண்டதொரு சிறிய சாசேத் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

கிச்செயல்முறையிலுள்ள கிடர்பாடுகள்

இதயச்சுவர் சிரை ஆன்ஜியோகிராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிரை தமனி நோயின் தன்மை — (ii) இதயத்தீன் ஏற்றியிறைத்தல் நிலை — (iii) இதயத்தீன் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புன்ன சில தீவிர கடர்பாடுகள் மின்வருமாறு. ஆனால் கிவைகள் மட்டுமே முழுமையான கிடர்பாடுகள் அல்ல

10.00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகிதம்)	(a) கதிர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதீப்பு. சருமம் சிவந்து போதல்
1000-ல் ஒருவருக்கு (0.001 சதவிகிதம்)	 (b) வலிப்பு. இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாரடைப்பு (d) எக்ஸ்-ரே காண்ட்ராஸ்ட் மீடியத்தீன் (டை) ஆபத்தான விளைவுகள் . இவை ஏற்பட்டால் உங்களுக்கு ஆஸ்துமா, அதீர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2.50,000 முதல் 4,00,000 ஊசிகளில் ஒன்று மரணத்தையும் விளைவிக்கலாம். (e) குத்தப்பட்ட இடத்தீல் பெரிய அறுவை சிகீச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரகால இதய அறுவை சிகீச்சை அல்லது ஆன்ஐயோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதீர் பாதீப்பு காரணமாக அதீக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	 (I) இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகீச்சை தேவைப்படும் (j) குத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகீச்சை சரிபாடு. இதனால் மருத்துவமளையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) கான்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலுகுறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவிலான சிராய்ப்பு அல்லது வீக்கம்
பெரும்பாலான மக்களுக்கு	(n) சிறிய அளவிலான சிராய்ப்பு

நோயாளி ஒப்புதல்

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

	கையெழுத்து	பெயர்	தேதி	நேரம்
நோயாளி (பாதுகாவலர்) உறவுமுறை				
சாட்சி	<u> </u>			
மருத்துவர் -	. •		,	
மொழிபெயர்ப்பானர்				







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

TRANSRADIAL PERCUTANEOUS CORONARY INTERVENTION REPORT

 Patient name
 MR. KANNAN GOVINDHAN
 ID
 MHI202481768

 Age/Gender
 44 M
 IP No.
 IPH2024000099

 Cath No.
 3599
 D.O.P.
 12.01.2024

Done by Dr. G.Gnanavelu

Technician: Mr. Prathap

Scrub nurse: Ms. Sharmila

DIAGNOSIS: CAD-EVOLVED IWMI; MILD LV DYSFUNCTION, SHTN;

CAG: DOUBLE VESSEL DISEASE OF LCX & LAD.

APPROACH: Right radial artery

EXPOSURE TIME: 1390 sec

HARDWARE: 6F hemostatic sheath, 6 F EBU 3.5 guide

RAK: 220 mGy

CONTRAST : OMNIPAQUE 200 ml

DAP: 109Gy.cm2

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

HEMODYNAMIC DATA: ABP 114/70 (84) PULSE 91 bpm SPO2 100%

ARTERY	LESION	GUIDE WIRE	PRE DILATATION	STENT	POST DILATATION	RESULT
DISTAL LCX	TOTAL OCCLUSION OF DISTAL LCX	WHISPER	2 X 10 SC Balloon 10 atms	ONYX TRUCOR 2.5 X 22mm & 2.5 X 12mm 18 atms 15 s	2.5 x 8 NC balloon 18 atms	FLOW
DISTAL LAD	80-90% STENOSIS	BMW	2 X 10 SC Balloon 10 atms	ONYX TRUCOR 2.25 X 18mm 16 atms 15 s	2.5 x 8 NC balloon 18 atms	TIMI III FLOW

REMARKS: Patient had chest pain after stenting of distal LCX. There was suspicious dissection of proximal edge of stent. Hence another overlapping was deployed. Inj Tirofuse 14 ml bolus was given and infusion at 8 ml started. Unj Nikorandil 2mg and aliquots of 50 mcg of Inj Sodium nitroprusside. Post procedure, patient developed severe chest pain in ICU. Check angio was done, which showed patent stents. IVUS was used to assess LCx stent. There was stent underexpansion distally. Hence postdilated with 2.75 x 8 balloon. Pain settled. ACT was 303 s.

RESULT: SUCCESSFUL PTCA X LAD & LCX.

Dr. G. GNANAVELU, MD, DM

Dr. G. Gnanavelu MD, DM (cardio), FACC Advisor & Mentor

#9, 1st Main Road, United India Colony, Kodambakkam, Chennai - 600024. Tel: 044 - 4310 895

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Chengalpattu

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

Medway Centre of Excellence (Chennai)

44/Male/MHI202481768

12/01/2024/IPH2024000099

Dr.G. GNANAVELU IN IN HUMAN IN

MHI/NUR/2022/048

		LEGICO COLLO DE LO COLLO DE LA COLLO DEL LA COLLO DE L		MHI/NUR/2022/048
I		NURSES PHOGHESS NOTES		
	Date & Time	Observations / Action		Signature with Emp. No.
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	11.	by PICA to LAD Alord ICC.		
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, ' , ,		5/02: 100-1- Vr-tals Stable.		
	18-25	25 Fri Tirofiban lam Rolly 51	<u>/</u>	AD
₫	<u> </u>	given ob Dr. Gluis)		John .
	14.45	=389: 127 94/106/mmths, HR: 88 b	HIMA	
	<u> </u>	bpos: 100 1. vitals stable.	- 	(V)
	14.50	=> Iti : Molszolam umb Tu giù	10/0	
		DR. Oak) Sir	<u> </u>	DV
	15.15	=> DN): Midazolam Imb DV 9WD	10/0	7
		DRGG (Sir)		
		- 1-1 Hepation 1500 Pu		7000
	15.10	=> A(T =) 205 sous -		
	. Document	Signature Name	Emp. No	. Date Time
	endorsed by	Mathriga	00/6	PURG 1540

	NU	JRSES PROGRESS NOTES		
Date & Time		Observations / Action		Signature with Emp. No.
15.20	=> INI Hepare	n 15080 zu gives	<u> </u>	
15:40	> TAB: Sorbit	rate 5 mb poral	geries	En
15.10		rate 5 mb oral	gui	
101.0	7	TO DE CE	1 0000	Toron
15.45	Ob Delah	, , , , , , , , , , , , , , , , , , ,	gens	
	SP Padral	1 1 10	mound	on
15.46	itight pressu	u bondage cyppl	ied	<u>'</u>
<i>N</i> * 0.3	no ooring	10 harlo		Gro
600	Sylva GB	COUNTY CUL	(
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	=> pt check 0	AG procedus	· · · · · · · · · · · · · · · · · · ·	
17-55	DNJ: S(V)	Hepaus Hogy	W	05
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	Signature	Name	Emp. No	Date Time
Document endorsed by	Jan	JAYDANSI	000	interpret





SAFE PROCEDURE CHECKLIST Adapted from WHO Safe Surgery Checklist



Mr.KANNAN GOVINDHAN

44/Male/MHI202481768 12/01/2024/IPH2024000099

Name of the Procedure :	p_p_	Location: COLH US	Date & Time : <i>_</i>	
Does the Procedure involve	/ Procedural Sedation : ☐	Yes ☐No		
SIGN IN Before Induction of Procedural S	edation	TIME OUT H 15 After procedural Sedation and before procedure		SIGN OUT CONTROL SIGN O
(Anaesthetist / Qualified Physicia Sedation + Nurse + Technician + Do		(Anaesthetist or Qualified Physician	administering Procedura performing the Procedura	Sedation + Nurse + Technician + Doctor ure
Patient Confirmation		All team members introduce themselves by Name and Role		To be done for each procedure in case of multiple procedures
Identity by two identifiers	Yes	Identity by two identifiers	∐Yes	Name of the Procedure done written down
Procedure	☑Yes	Procedures DIC/T	☑Yes	Name and site of all specimens / investigations ☐ Yes ☐ NA
Side	DRI DIL DNA	Expected Blood loss	, DRT DLI DNA	confirms labeling and sent to lab .
Consent	☐Yes	Position SUDINE	•∐Yes	Any recovery concerns : ☐ Yes ☐ Yone
Known Allergy	☐Yes ☐Mo	Consent	1 Yes_	If Yes, Pls. specify:
	If yes, plaese specify	Required equipment and implants available	PYes NA	If Yes, Pls. specify: Observation
Difficult airway / aspiration risk	☑No ☐ Yes, equipment	Essential Imaging displayed	☑Yes □NA	1
/ dentures	and assistance available	Antibiotic prophylaxis within last 60 minutes	Yes WA	· _
Possibility of hypothermia	☑ No ☐ Yes, warmer in place	Name of the Antibiotic given		Any Equipment / instrument problem that needs to be
		Venous Thromboembolism Prophylaxis Provided	☐ Yes ☑ ANA	addressed : ☐ Yes ☐ None If Yes, Pls. specify :
All concerned anesthesia equipment	and medication check complete	Anticipated duration briefed	☑Yes-	il tes, ris. specify.
☐8po2 ☐NtBP ☐0ther	rs pls. specify F1 5	Anticipated blood loss briefed	☐Y95 ☐NA	/ 1 /
Pre OP medication taken	Yes 🗆 🗸	Adequate fluids and blood available	Yes DNA	/ /
Fre OF medication taken		Team briefed on any critical or unexpected steps	-€ Yes	Corrective action :
Required equipment for	☐ Yes ☐MA	For procedural sedation cases		
procedure available		Any patient specific concerns :	☐Yes ☐None	
		Intra procedure glycernic control Any concerns about sterility	☐ Yes ☐ NA ☐ Yes ☐ Norte	
	<u> </u>		,	<u></u>
Anaesthetist / Doetor giving	Doctor performing th	he Nurse: SN Sathuff, T	echnician : PONOL	Others Please Specify:
Procedural Sedation	Procedure :	993719	7	2507
l. ' /		1 4 1 . /_ 1	10/1/01	
Date:	Date: 2 2	\ .	Date: 21/29	Date:
Time:	Time: 15 4-3	Time: 15.11	ime: 15 14 6	Time:



Heart
Institute
Every heart beat counts

Mr.KANNAN GOVINDHAN

44/Malc/MHI202481768

Patient Name

12/01/2024/IPH2024000099

Dr.G. GNANAVELU

Consultant:

THE REPORT AND THE PROPERTY OF
GIOGRAM / CORONARY ANGIOPLASTY

Sex: M/F

UHID

CONDITION AND PROCEDURE

Dr Dan M.E. Was explained that I have the following condition:

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

RISKS OF THIS PROCEDURE

The risk of coronary angiography depends on:

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

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

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

On the basis of the above statements,

I REQUEST TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship		_ ;		
witness	her	RAMES-C+	12 124	14.10
Doctor	\$930V	or soldban bouthi	121124	1.10
Interpreter	,		1,141,141	





இருதுய ஆன்றியோகிராம் பரிசோதனைக்கான ஒப்பம்

Every	heart	beat	counts
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நோயானியின் பெயர்:	ា	பாலினம்: ஆண் / பெண்
மருத்துவ ஆனோசகர்:	வார்டு படுக்கை எண்:	யுஹெச்கழ (UHID) :

நிலை மற்றும் செயல்முறை

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

கீச்செயல்முறையிலுள்ள கிடர்பாடுகள்

இதயச்சுவர் சிரை ஆன்ஜியோகீராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்தீருக்கும்

(i) இதயச்சுவர் சிரை தமனி நோயின் தன்மை (ii) இதயத்தீன் ஏற்றியிறைத்தல் நீலை (iii) இதயத்தீன் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள சில தீவிர கீடர்பாடுகள் பின்வருமாறு. ஆனால் கிவைகள் மட்டுமே முழுமையான கீடர்பாடுகள் அல்ல

10,00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகீதம்)	(a) கதிர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
1000-ல் ஒருவருக்கு (0.001 சதவிகீதம்)	 (b) வலிப்பு. இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாரடைப்பு (d) எக்ஸ்-ரே காண்ட்ராஸ்ட் மீடியத்தீன் (டை) ஆபத்தான விளைவுகள் . இவை ஏற்பட்டால் உங்களுக்கு ஆஸ்துமா, அதீர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2.50,000 முதல் 4.00.000 ஊசிகளில் ஒன்று மரணத்தையும் விளைவிக்கலாம். (e) குத்தப்பட்ட இடத்தீல் பெரிய அறுவை சிகீச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரகால இதய அறுவை சிகீச்சை அல்லது ஆன்ஜியோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதீர் பாதீப்பு காரணமாக அதிக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகீதம்)	 (1) இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகீச்சை தேவைப்படும் (j) குத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகீச்சை சரிபாடு. இதனால் மருத்துவமளையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) கான்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வனுகுறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகீதம்)	(m) குத்தப்பட்ட இடத்தீல் பெரிய அளவிலான சிராய்ப்பு அல்லது வீக்கம்
வரும்பாலான மக்களுக்கு	(n) சிறிய அளவிலான சிராப்ப்பு

நோயாளி ஒப்புதல்

செயல்முறையையும் எனக்கு விளக்கீனார். செயல்முறையிலுள்ள இடர்பாடுகள், மயக்க மருந்துகள் உடபட எனக்கு குறிப்பாக ஏற்படும் இடர்பாடுகள் மற்றும் சிக்கல்கள் ஏற்பட்டால் என்னவாகும் என்பவைகளை நான் புரிந்து கொண்டள்ளேன். மருத்துவர் பிற தொடர்புள்ள சிகீச்சை விருப்பத் தேர்வுகள். அதன் இடா்பாடுகள் மற்றும் சிகீச்சை மறுப்பதற்கான என்னுடைய உரிமை ஆகீயவைகளையும் எனக்கு விளக்கினார். அவர் என்னுடைய முன் கணிப்புகள் மற்றும் செயல்முறையை மேற்கொள்ளாமல் இருப்பதால் ஏற்பட வாய்ப்புள்ள இடர்பாடுகள் ஆகியவைகளையும் எனக்கு விளக்கினார். என்னுடைய நிலை குறித்து என்னால் கேள்வி எழுப்ப முடிந்தது மற்றும் என்னுடைய கவலைகளை தெரிவிக்கவும். செயல்முறை மற்றும் அதன் பலன்களை தெரிவிக்கவும் மற்றும் எனது சிகீச்சை விருப்பத்தேர்வுகள் குறித்த கவகைகளையும் என்னால் தெரிவிக்க முடிந்தது. என்னுடைய கேள்விகளும் மற்றும் கவகைகளும் கலந்தாலோசிக்கப்பட்டது மற்றும் எனக்கு திருப்திகரமான முறையில் அவற்றிற்கு பதிலளிக்கப்பட்டது. அசாதாரணமான குழுவில், எனக்கு இரத்தமேற்றுதல், ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகீச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டுள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகீச்சையளிக்கப்டும் என்பதை எனக்கு விளக்கினார். இச்செயல்முறையினால் என்னுடைய நீலை மேம்படும் என்பதற்கு எத்தகைய உத்திரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டுள்ளேன்.

சையல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

	கையெழுத்து	பெயர்	தேதி	நேரம்
நோயானி (பாதுகாவலர்) உறவுமுறை				
சாட்சி	*1			
. மருத்துவர்	•			
மொழிபெயர்ப்பாளர்				





SAFE PROCEDURE CHECKLIST Adapted from WHO Safe Surgery Checklist



Ev Mr.KANNAN GOVINDHAN

44/Malc/MHI202481768 12/01/200

Name of the Procedure :	CAG1	Location: Cath	del	Date & Time :	
Does the Procedure involve F	Procedural Sedation :				
SIGN IN 3.1.1 Before Induction of Procedural Sed	<u>\</u>	TIME OUT 1 13.50 After procedural Sedation and before pro			SIGN OUT When Doctor indicates that the Procedure is completed
(Anaesthetist / Qualified Physician a _Sedation + Nurse + Technician + Doctor	administering Procedural or performing the procedure)	(Anaesthetist or Qual	lified Physician a	dministering Procedura performing the Proced	al Sedation + Nurse + Technician + Doctor dure
Patient Confirmation		All team members introduce themselves by N	Name and Role		To be done for each procedure in case of multiple procedures
Identity by two identifiers	☑Yes	Identity by two identifiers		QYes	Name of the Procedure done written down \ \(\frac{1}{4} \)
	∐Yes	Procedures (1)	,	□Yes	Name and site of all specimens / investigations ☐ Yes ☐ NA confirms labeling and sent to lab
Side	□#f □ Lt □NA	Expected Blood loss NA	appsouh.	ÖR+ ÖLt □NA	
	☑Yes	Position Suping		Yes	Any recovery concerns :
	□Yes ☑₩o	Consent		☐ Yes	If Yes, Pls. specify:
<u>.</u>	If yes, plaese specify	Required equipment and implants available		☐Yes ☐NA	Observation
	☑No ☐ Yes, equipment	Essential Imaging displayed	•	☐Yes ☐NA	
	and assistance available	Antiblotic prophylaxis within last 60 minutes		☐Yes ☐NA	
Possibility of hypothermia	🗀 No 🗀 Yes, warmer in place	Name of the Antibiotic given		<u> </u>	Any Equipment / instrument problem that needs to be addressed: ☐ Yes ☐ None
		Venous Thromboembolism Prophylaxis Prov	rided	☐Yes ☐NA	If Yes, Pls. specify:
All concerned anesthesia equipment an	d-medication check complete	Anticipated duration briefed		□Yes	
Depo2 DNIBP Dothers	pls. specify <u>F(()</u>	Anticipated blood loss briefed		∠ Yes □ NA	
Pre OP medication taken	☐ Yes ☐ No	Adequate fluids and blood available		□Yes □NA	
		Team briefed on any critical or unexpected s	teps	☐Yes	Corrective action :
	☐Yes ☐ÑÂ	For procedural sedation cases		☐Yes ☐None	
procedure available		Any patient specific concerns : Intra procedure glycemic control		Yes NA	
		Any concerns about sterility		☐Yes ☐None	<u> </u>
Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure :		igi Te	chnician: braff	Others Please Specify:
Date :	Date : 12/1/24	Date: 12-(1/24)	I .	nte: (2) 1/24 ne:	Date :





(A Unit of United Alliance Healthcare Pvt Ltd)

Procedure Monitoring Sheet (Cath Lab)

Every heart beat counts

Mr.K	ANNAN	GOVINDHAN

Patient Nam€

44/Malc/MHI202481768

12/01/2024/IPH2024000099

UHID / IP:

Dr.G. GNANAVELU

Consultant :

Age / Sex : HAY IM.

Ward Unit:

at floor

Diagnosis: CAD -DUD

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

PARAMETERS	YES	ИО	NA
Vital signs : BP://30.l8oTemp:98:6. Pulse:.98. RR:86. SPO2:98	, , ,	i	
Urine voided			
Bowel preparation		/	
Pre-procedure medication administered	/		
Procedure site marked			
Skin preparation done	/		
NPO 8.00	V		
Loose Tooth removed			
Contact lenses / Eye glasses removed			
Prosthesis present			/
Jewellery/Nail polish removed			
Checked for Allergies (Drug / food)			1 , ,
IV line/In-situ			
Consent taken	V		
Investigation reports / Documents received			
Signature of Nurse:	Date & Time :	124/200	nt 13.125

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

Time	HR / min	RR / min	BP mmHg	SpO ₂ %	Medication / Remarks	Sign. of Nurse
13.55	2015 Hmin	is br/min	12/87/94	100%		Hoson
4.15	83b) min	2) by/min	b1 87095	100/		Dozon
4.30	&bt/m/n	J. br/m/n	116/88(49)	100%		Doson
14:45	816+1min	alming to	127/14 (106)	100-/:-		O por
15.00	876HM	20br/min	120 Rb (104)	100./,		Cooper
15.30	846Hm/n	DD br Molo	127/72/102	1		alow_
			proceden	907 OU	er -	
			Ĭ			

Time :			14:30	Route :	Rt Radics	2 centrey	<u> </u>
Comp	lication:	Νį	ĺ)		•	dpr	o Valy
BP : _	124/86	094	<u>∕)</u> mmHg, HR	2: <u>&9 bHm/h</u> , RR:	22 by my spoz	2:	<u>0 /</u> ,
Distal	Pulse:	ン 	felt	R: St. b. / //n //n , RR: , Puncture Site: ///0 <i>Q</i>	ozing no A	centon	•/
Advis							
	nift To: Wa		! A				
	ed rest up bserve pu		site for bleedir	hours			
♦ W	atch for P			₩ artery.			
♦ Di	et						
	=		cal Officer SOS				
	•	•	plains of any Di _oose or Socke				4
	If limbs a	`	old / Absent/Pul	lse ressing on	2C at /9.1	50 AM /PM	affer informing
to	the consu	ítant.		1000 mg on	<u></u>	/ / / / / / / / / / / / / / / / / / /	diel morning
♦ Sp	ecial inst	ructior د اا	າ if any:	•		1/200	\sim
		10	1 [N	lame & Signature	of Consultant
				POST PROCEDURE OF	SERVATION		
Date & Time	BP	HR	RR SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse
以斯特	\$20/94	86 Þ	· 100/-	no oozin no	Good		A Do
	<u> </u>	-					_
				 	<u> </u>		1
	,						
							
Nurses	Notes:		•	. 4			•
	C	Aln	+ DT(A	procedure d t tight pre heunton co	one P+	Podent	Mour
	. 0	וְעני		ticht ma	ocia land	lago a	ma less 1
cl	heath	y	mould	e agra pre	sue soura	uge y	grees
N	1.60 1/2	クフィ	ña vw	heenton Co	with hit	1	• • •
		000	7				
Condit	ion at the	and a	f procedure :	Stable G Ce	tical		
	t shift to:			Room Patient Room	ilical ☐ CCU ☐ Othe	er 🔥 11	1
			the Nurse:	2	Date & Time		,
			\	520	Q (olipy Ki	

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



44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





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PATIE	NT TRANS	SFER FC	RM DIA	GNC	STICS	/ PROCED	URI	ES	
Diagnosis:	CAD-	DV.D	Alle	rgies i	f any:	NKOA			
From (Area)		(Area)		Гime		for Transfer / Na	ame of	Pro	cedure
13+ floor	Cath	lab	12/1/24/13	3-2 <u>5</u>	. CI	Gipa			
Method of Trans	sfer: 🗌 On Bed					<u> </u>			
ASSESSMENT General condition	OF PATIENT: on of Patient:	Conscious [☐ Semi-consci	ous 🗆	Un-consci	ous			
Language Barri	er: 🗌 Yes 🗌 No	☐ If Yes, spe	ecify:						
Fall Risk Catego	ory: Low Risk [Medium Ri	sk 🗌 High Risl	<					
Vital Signs (to be	documented at t	he time of shif	iting):						
Temp (°F)	RR (breaths/mi	n) Puls	e (beats/min)		SpO ₂ (%)	BP (mmHg)	_ F	ain	Score
9-1.6°E	20 blmin	90	blmin.	_	98%	120/70		1	0,
☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years) ☐ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose) Any pre-medication given: ☐ Any critical information: ☐ Any specific recommendation:									
	Signature	Nai	ne	~		Emp. No.	Date		Time
Handover by			A. Nam!	hin	,	017-2	12/1	24	13.29
Handed over to			_V. &215	sny	12	0102	12/),	24	13.20
After Procedure: Procedure completed: Yes Any critical information:									
Vital Signs (to be					C-O (0()	DD (mm-Ha)			
Temp (°F)	RR (breaths/mi	n) Puis	e (beats/min)		SpO ₂ (%)	BP (mmHg)	<u> </u>	1/	Score
Pain Scale used: \Box PIPPS (28 weeks to \leq 38 weeks) \Box CRIES (38 weeks - 2 months)									
☐ FLAGC Scale	•	ırs) 🗆 Wong	-Baker FACES	Pain R	ating Scale	onins) (7 years - 12 years	s)		
	Signature	Nat	ne 1 1 -			Emp. No.	Date		Time
Handover by	0		Of in	xya		010-	12	24	16.00
Handed over to	Q	.]	1) orthor	\mathcal{Q}_{a}	J	0240	(2)	24	1610





CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

3/7 - 3/A	MAM	GOVINDHAN	

Patient Name 44/Mulc/MHI202481768

12/01/2024/IPH2024000099

Dr.G. GNANAVELU

Sex: M/F

UHID

CONDITION AND PI

Consultant:

Dr ... OHNANAVEUhas explained that I have the following condition:

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

RISKS OF THIS PROCEDURE

The risk of coronary angiography depends on:

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

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

PATIENT CONSENT

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

I REQUEST TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship	0) 1/2 0	hhomma. Comon	12.1.28	18.00
witness	Rollinger	K. Luyyo.	12.1.00	18.00
Doctor	9836	DR-VARTHI	12-1-21	5.00
Interpreter		100	1	12-30





இருதய ஆன்னியோகிராம் பரிசோதனைக்கான ஒப்பம்

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

நிலை மற்றும் செயல்முறை

பழைய இரும்புக் குழாய்களில் துருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியும் சேகும். இது ஆன்ஜினா அல்லது மாரடைப்பிணை ஏற்படுத்துகிறது. இதயத்தீற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிரை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியரேகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு மோக்கல் அன்றத்படிக் (மயக்க மருந்து) வழங்கப்பட்ட பின். ஒரு சிறிய குழாயானது (கதீட்டர்) கவட்டை/கையிலுள்ள தமனியில் செலுத்தப்படும், இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிரை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டுள்ளன காண்டுராஸ்ட் மீடியத்தினை (எண்ஸ்ரே டை.) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுயக்க இருதய கீழறை) இந்த காண்டிராஸ்ட் மீடியும் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்ப் செய்கிறது என்பதை மதிப்படவும் மேற்கொள்ளப்படும். இப்படங்கள் நமக்கு இதயச்சுவர்சிரை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கன் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகீட்சையை மேற்கொள்ள முடியும். இடை பை-பான் அறுவை சிகீட்சையாகவும் இருக்கலாம். அலைவ் மடிந்துகள் மடிடுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

தெச்சையல்முறையிலுள்ள கிடர்பாடுகள்

இதயச்சுவர் சிரை ஆன்ஜியோகிராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிரை தமனி நோயின் தன்மை — (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை — (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள சில தீ**விர இடர்பாடுகள் பின்வருமாறு. ஆனால் கீலைகள் மட்டுமே முழுமையான கிடர்பாடுகள் அல்ல**

10,00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகீதம்)	(a) கதீர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
1000-ல் ஒருவருக்கு (0.001 சதவிகிதம்)	 (b) வலிப்பு. இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாரடைப்பு (d) எக்ஸ்-ரே காண்ட்ராஸ்ட் மீடியத்தின் (டை) ஆபத்தான விளைவுகள் . இவை ஏற்பட்டால் உங்களுக்கு ஆஸ்துமா, அதீர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2.50,000 முதல் 4.00,000 ஊசிகளில் ஒன்று மரணத்தையும் விளைவிக்கலாம். (e) குத்தப்பட்ட இடத்தில் பெரிய அறுவை சிகீச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரகால இதய அறுவை சிகீச்சை அல்லது ஆன்ஜியோபினாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதிர் பாதிப்பு காரணமாக அதீக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்) ்	 (1)இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம், அதற்கு அவசரமாக சிகீச்சை தேவைப்படும் (j) குத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகீச்சை சரிபாடு. இதனால் மருத்துவமளையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) கான்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலுகுறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவிலான சிராய்ப்பு அல்லது வீக்கம்
பெரும்பாலான மக்களுக்கு	(n) சிறிய அளவிலான சிறாய்ப்பு

நோயாளி ஒப்புதல்

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

	கையெழுத்து	பெயர்	தேதி	நேரம்
நோயாளி (பாதுகாவலர்) உறவுமுறை				
சாட்சி	_	-		1
மருத்துவர்				
மைரழிபெயர்ப்பாளர்			,	





(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.KANNAN GOVINDHAN

Procedure Monitoring Sheet (Cath Lab)

Every heart beat counts

	Pat		Male/MHI202481768		. Age	/ Sex:	:	
	UH	ID/IP: Dr.	01/2024/iPH2024000 3. Gnanavelu	j	War	rd Unit :	ŀ	
	Co	nsultant:			Diag	gnosis :		
		Pre	Procedure Che	ecklist (Please tick a	ppropriately – To	be filled by the V	Vard Nurse)	
			PARAMET	ERS		YES	, NO	NA
Vi	tal si	gns : BP:(ን.১.) .	18mp:98.6.P	ulse: \$1 RR:2	SP02: 95		ri Li	
Ut	ine v	oided/						
Во	wel	preparation						
Pr	e-pro	ocedure medica	tion administered	d				
Pr	ocec	lure site marked	<u> </u>				,	
Sk	in pr	reparation done		•,	•		١,	
NF	90				_			
Lo	ose	Tooth removed				,		
Co	ontac	t lenses / Eye g	lasses removed					
Pr	osth	esis present					\dagger	•
Je	welle	ery/Nail polish re	emoved					
Ch	eck	ed for Allergies ((Drug / food)					
IV	line/	In-situ						
Co	nse	nt taken						
In	/esti	gation reports	Pocuments rece	ived				<i>C</i> .
Si	gnati	ure of Nurse :	EN			Date & Time :	12/1/24	@ (b \ BT
_	_		Intra – Pro	ocedural Record	(To be filled by the	e Cath Lab Nurse)	.
Tii	ne	HR / min	RR / min	BP mmHg	SpO ₂ %	Medication	/ Remarks	Sign. of Nurse
73	5	896+Amin	22 br/m/s	117/86/04	100%		<u> </u>	Doso
L ://		896+lmin	n.b.min	18/90/102	100%.	_		Poson
	<u>-:-</u>			mol	1 / //	an1 1	10x -	
				10.00				
					_	·		

			Post Proce	edure Follow Up Data (to	o be filled by the do	octor)	
Time :			18.10	Route:	Rt Semora	atogg	aponoah
Compli	cation : β	ù)	·			0	/ 60 0000
		(95)	_mmHg, HR	: & 16) / M/n_ , RR : , Puncture Site: <u>N /</u> 0	Debi/mjb, sp02 Dozurg no chae	:100, inton	·/,
Advise): -						
♦ Bed ♦ Obs	serve pur itch for Pi	to ncture si	ite for bleedjr	hours Martery.			
a) b) c) ♦ Rer to ti	If patient	complaing is Local are Cold Lank.	/ Absent Pul Movaa_ di	scomfort d with Blood		AM /PK4	28 ⁵
				POST PROCEDURE OF		- Congrictore	- Or Consultant
Date & Time	ВР	HR RF	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse
Date a Time			1 0,0270			, tottianto	Olgin of Mares
	<u>-</u>				1		
							- 1
							1
	_						
Nurses	Notes:	R+ uttie	femori sow zare	al certagy is, and with sub	heath son two pledo	ued p Landa	eg zió ye ggplæs
	on at the	end of p	rocedure :	Stable Cr	itical		- f. l
	shift to:			Room Patient Room	CCU Othe	r	
Name 8	k Signatu	re of the	Nurse		Date & Time:	21/24 18:	NS .



44/Male/MHI202481768
 12/01/2024/iPH2024000099

Dr.G. GNANAVELU









NURSING ADMISSION ASSESSMENT (ADULT)

tterretter / E = E = E = E = E = E = E = E = E = E							
Date of Admission: 12 1 24 Time of Arrival: 2 20 Mode of Admission: Walking Wheelchair Stretche							
Accompanied by Relative: Yes No if Yes, Name of the Relative:							
Relationship with Patient: Anna. Contact Person's Name: Relationship:							
Contact No.: 38339hb73 Primary language spoken; Tamil English Indian International							
Interpreter needed: Yes No Patient status: Conscious Unconscious Disoriented							
Menstrual History: LMP: Menopause: Patient Vulnerable: Yes							
Medical History: DM / HTM / Co - Morbidity:							
Drugs History : Antiplatelet (Specify)							
Psychological Status: Anxious Withdrawn Agitated Depressed Sleeping Difficulty							
- Wer the past 2 weeks, how often have Not at Several More than one Nearly							
J been bothered by any of the following all Days half of the days every day problems?							
Little Interest or pleasure in doing things 0 1 2 3 0							
2. Feeling down, depressed, or hopeless 0 1 2 3							
Scoring: A PHQ-2 score ranges from 0 to 6; patients with total score of 3 or more should be further evaluated with							
Columbia-suicide Severity Rating Scale (C-SSRS)tool.							
Do you have any special religious, spiritual or cultural needs to be considered? Tes No If Yes, specify details:							
Socio Economic Status: Fmptoyed Retired Own Business Home-Maker Others:							
Vital Signs: Temp: 98.6 (°F) Pulse / HR: 8 4 (beats/min) BP: 00 18 (mmHg)							
Respiration: (breaths/min) SpO ₂ : (%) CBG: (mg/dl) Height: (6cms) Weight: 6cms)							
Allergies / Adverse Reaction: Yes Mo Medication Blood Transfusion Food Not known							
If Yes, specify:							
Pain: Yes No. If Yes, Score: Yes Pain Scale Used: NRS (>12 years) CPOT (ventilator / comatose							
ration: Location: Location:							
ו Character: עוו Aching Sharp Stabbing Shooting Burning Referred / Radiant Pain							
Nutritional Screening: st 3 months Appetite: Increased Decreased No Change							
Last 3 months Weight: Increased Decreased No Change Type of Patient: Diabetic Non Diabetic Type of Diet:							
Type of Patient: Diabetic Mon Diabetic Type of Diet:							
Dietician Informed: Yes No. If Yes, mention the Name: mls. co. hr Time: 2:3 d							
Orient Patient if: Conscious Orient Patient Attendant if: Unconscious Disoriented							
Room Side Rails Toilet Bell Patient Information Board Bathroom Bed Controls							
Use of Footstool Grab Bars Nurses Call Bell Television Light Controls Telephone							
Functional Assessment:							
D attended to the second of th							
Particular Assessment Remarks Outcome							
Visual Impairment Yes No							
Visual Impairment Yes No							

			* 3.							
Daily Activity Of L	.iving:									, ' 1, ' 1
Activity		Independe	ent	,	Assisted		_	Dep	ende	
Bathing							-		$\overline{\Box}$	<u></u>
Dressing			-			-				
Eating			-			<u> </u>				
Walking		 			一一					
Toilet Use	,								$\overline{\Box}$	
Pressure Injury R	iek Accas	ement: Brac	ien Scale	-				_	<u> </u>	
Sensory Percep		Score	Moisture		Score	Dogra	ee of A	ctivity	, –	Score
No Impairment	ALIOLI	A	Rarely Mois		3core		Frequ		<u>'</u>	Score 4
Slightly Limited		3	Occasional		3		Occas		v	3
Very Limited		2	Very Moist	,	2	Chair		Jorian	,	2
Completely Limit	ted	1	Constantly I	Moist	1	Bed F				
Mobility		Score	Nutrition		Score	Fricti	on & S	hear		Score
No Limitation		4	Excellent		4	-	parent		em	/3
Slightly Limited		3	Adequate		3		ntial Pro			2
Very Limited		2	Probably In-	-Adequate	2	Probl	em Pre	esent		1
Completely imm	obile	1	Very Poor	•	1	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 No If yes, Location: Grade: Size: Relationship: Relationship:									
		<u> </u>	E FALL ASSES		•	bove 16	years)		
Fall Risk Assess	sment (Mc	odified Mors	ie Scale):		• •					
Variables									Nun	neric Value
History of falling	(immediat	e or within 6	months)			•	-	No Yes		25
	_					/	_	No		0
Secondary diagr	ıosis (≥ 2	medical diag	jnosis)				<u> </u>	Yes		
Ambulatory Aid None / Bed Rest		ssist		-					,	-
Crutches / Cane										15
Furniture				٠						30
Intravenous Ther	apy / Hep	arin Lock / To	ubes Insitu					No Yes		0 20
Gait Normal / Bed Re		Chair	•		-					<u> </u>
Weak	St/ Wilcei	Oriali								10
Impaired										20
Mental Status Oriented to own	etability									
Overestimated o		mitations					-			15
Medications Includes PCA / o			anti-hyperter	nsives diuret	ice hypnotic	~e		N-		
laxatives, hypogl							<u> </u>	No Yes		15
					-	T=1-1 C	_	.55		
Score Interpretation	n: 0-24: Low	/-risk; 25-44: N	леашт Risk; Ab	ove 45: High l	risk	Total Sc	core		マ	U

.4

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٠.

'As per the score, tick the following appropriate	boxe	s:	
Familiarize the patient with the immediate surroundings. 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 the Remove excess equipment or furniture to make a clear. Keep the patient's bed in the low position at all times extended the patient's bed in the low position at all times extended the patient's bed in the low position at all times extended the patient's bed in the low position at all times extended the patient's bed in the low position at all times extended the patient's bed in the low position at all times extended the patient's bed wheels should be locked. Encourage family participation in the patient's care. Ensure that floor of the bathroom is dry and not slippent. Review medications for potential side effects that can patient to 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 / Stretch bed or wheel chair or on a toilet seat. Use restraints and bed monitors as ordered by the document of the patient to ambulate only with assistance. Consider peak effects of the medications that effect elimination when planning patient's care. Do not leave patients unattended in diagnostic or treating accompany the patient while going to bathroom. Advice the patient to use grab bars near the toilet, bathroom.	bed for all the pat path cept d a mor y promo re to b cher uted for the path cept d a mor y promo re to b cher uted for the path cept d a mor y promo	tient's during ment te fal e am or hes	s easy reach g procedure t before rising from the bed Ils abulated only with assistance avy or debilitated patients in a
	restric . ses' st riate) h then	etions ation	s mentioned above
Make sure the family and other visitors understand the High-risk interventions (above 45) □ Apply all the low and medium risk interventions □ Tie red fall risk tag in the bed, wheel chair and stretcher □ Locate the high-risk patients in a room close to the nurs □ Answer these patients call bells as quickly as possible □ Provide a commode at bedside (if appropriate) □ Urinal/bedpan should be within easy reach (if appropriate) □ Encourage family members or other visitors to stay with If appropriate, consider using protection devices: safeten	restrice. ses' st riate) h then ty belt	ations	s mentioned above
 ✓ Make sure the family and other visitors understand the High-risk interventions (above 45) ☐ Apply all the low and medium risk interventions ☐ Tie red fall risk tag in the bed, wheel chair and stretcher ☐ Locate the high-risk patients in a room close to the nurs ☐ Answer these patients call bells as quickly as possible ☐ Provide a commode at bedside (if appropriate) ☐ Urinal / bedpan should be within easy reach (if appropriate) ☐ Encourage family members or other visitors to stay with 	restrice. ses' st riate) h then ty belt	ations	s mentioned above
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☐ Make sure the family and other visitors understand the High-risk interventions (above 45) ☐ Apply all the low and medium risk interventions ☐ Tie red fall risk tag in the bed, wheel chair and stretcher ☐ Locate the high-risk patients in a room close to the nurs ☐ Answer these patients call bells as quickly as possible ☐ Provide a commode at bedside (if appropriate) ☐ Urinal / bedpan should be within easy reach (if appropriate) ☐ Encourage family members or other visitors to stay with ☐ If appropriate, consider using protection devices: safet Initial Assessment to Special Needs and Vulnera Terminally ill patients Patients with intense chronic pain 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	restrices. ses' st riate) th them ty belts	ations	s mentioned above
	restrices. ses' st riate) th them ty belts	ation s	s mentioned above
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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.	Assign a s			Paran			1105. 1-10		assign a sc		- 01 -2 II (1E3) IN P		Yes / No	<u> </u>	Score
1	Active cancer	ive cancer (on-going treatment or diagnosed within 6 months or palliative care))	 _ -		No	30016
2	Bedridden red										<u> </u>	<u> </u>		νο	
3		>3 cn	n compare			<u> </u>			red at 10 cm	n be	low tibial tubercle			No.	
4	Collateral (no	nvaric	ose) super	ficial v	eins j	orese	nt (Asses:	s for both	legs)				Yes 1	No	
5															
6	Localized tend	derne	ss along the	e deep	ven	ous sy	 rstem (As	sess for b	ooth legs)	_		一	Yes 7	No.	
7	Pitting edema	, grea	ter in the sy	mptor	natio	leg (A	 ∖ssess foi	both leg	s)				Yes 1	10	
8	Paralysis, par	esis, o	or recent pla	aster in	nmol	oilizat	ion of the	lowerext	remity (Asse	ess f	or both legs)		Yes 7	VO	
9	Previously do	cume	nted DVT (/	Assess	forb	oth le	gs)						Yes 🔀 I	Vo.	
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.														
	Risk Score Interpretation (Probability of DVT): Tick the score obtained (1)								<u>}</u>	inal Sco	re				
		, -		<u>√</u>					Action Tak	ken			Date		Time
Low	Risk		2 to 0		4	-									
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Hig	h Risk	[3	3 to 8									_			
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Othe (spe	r valuables			_	<u> </u>					_					
Rep	oort (List of X-	ray, E	ECG, lab ı	report 	s ret	ained	d with th	e nurse) ————):	_				_	
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Uni	Patient / Patient's Attendant Pur PamESrt Nurse Patient's Attendant Pur PamESrt Unit In-Charge Dhanavave				٥	.005	12	101/24	16	ס <i>ט</i> !כ					

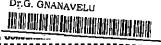






MI.KANNAN GOVINDHAN 44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





PATIENT CLINICAL HANDOVER RECORD FOR NURSES								
Date: _v	100	Shift: Morn	ing Evening N	ight		,		
S	Ventilator Periphera Ryle's Tul Urinary C	S: OHD DE	: :	GCS:r POD: Central line of VIP Score: Decify organis	days:	,		
В	On room		m siv	Date of surg	_	-		
A	Others: Pain Sco Fall Risk Braden S Pressure	ns: Temp: <u>48</u> (°F) Pulse /	(%) Height: (6 0 (cr : PIPPS / CRIES / FLACO ptocol: □ Low □ Medium At Risk-Mild Risk: 18-15 □ SH): □ Yes □ No □ NA	ms) Weight: C / Wong-Bak m	<u>6ፍ ካ</u> (kgs) BMI: <u>ዓ</u> ser FACES Pain Ratin	g Scale /NR	e Risk: 9-6	
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: follow-up orders: instructions if any:	١	are plan date	o:	÷		
		Signature	Name		Emp. No.	Date	Time	
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Mr. KANNAN GOVINDHAN ⁴⁴/Malc/MHI202481768 12/01/2024/142024000099 Dr.G. GNANAVELU



	PATIE	NT CLINICAL I	HANDOVER RECOF	RD FOR NUF	RSES	
Date:	10	Shift: Mor	ning Evening Night	re I y	,	
S	NEWS / F Ventilator Periphera Ryle's Tul	SEWS Score: day: line day: Right: Le be: Yes No Da atheter: Yes		0/5	· · ·	
В		urgery:	1 -	W. C.		
A	BP: 20 Others: Pain Sco Fall Risk Braden S Pressure Current o	re: O Pain Scale used Score: Fall Risk Program Ulcer Scale for Healing (PUlliet:		t: <u>6≲ </u>	2 3 6 kg ng Scale / NR	8 / CPOT e Risk: 9-6
R	Referral of Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections	s: Ano. If Yes, modified care plan da	nte:	-	
_	_	Signature	Name	Emp. No.	Date	Time
Handover (given by		A. Nanthini	410	12/124	12:0
Handover t	aken by	, i @	Olfmaye	0202	12/1/24	13.40
Document	endorsed	Josh:	JAYADA A	BAN	11/1/200	13.6

·	NURSES PROGRESS NOTES	
Date & Time	Observations / Action	Signature with Emp. No.
	Morning duty Notes - Patient taten over from. Night duty Stabl Lurde - patient Conscious & oriented - patient vital Signs Checkeds Perovided	
% 00	redication given as per- draig Chart Today plan for Clock	
15 Qs	> Preparation done, Consent +aten => patient Shifted to	
		;
Document endorsed by	Signature Name Emp. No Jay DAMARAI) DON	Date Time





44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date:	Shift: Morning Evening Night							
S	Ventilator Periphera Ryle's Tul	BEWS Score: day: I line day: Right: be: Yes No atheter: Yes No	POD: 1 - Central lin	e days:		. IX		
B	On room	ROUND urgery: アインラード if any: ハレのカ air / oxygen; Rብ ats / New Symptoms in las	, · , · · · IV fluids o	rgery: 12 1 2 1 1 1 1 1 1 1		∟(h.		
A	Vital Signs: Temp 24 (F) Pulse / HR:							
R	Referration Pending Pending Pending Critical vertical ver	medications: medication indent: lab reports / Investigations alue alert and its correction		ate:	_	•		
l		Signature	Name	Emp. No.	Date	Time		
Handover given by		(A)	Nathiya.	0240	12/1/24	9,30		
Handover taken by		O.	SUMA MAHTERWAR	028	12/1/24	18,30		
Document endorsed		Doyl	1 AYAPANY	800	· plily	19130		

NURSES PROGRESS NOTES						
Date & Time	Observations / Action	Signature with Emp. No.				
	Evening duty Motes.					
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 	Continue LVF 30 mc Montrow					
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Patient Netails (Affix Label here)

Mr.KANNAN GOVINDHAN

44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





PATIENT CLINICAL HANDOVER RECORD FOR NURSES
Date: 12 1 Shift: Morning Evening Night
SITUATION Diagnosis: COD - DV D NEWS / PEWS Score: Ventilator day: Peripheral line day: Right: Ryle's Tube:
BACKGROUND Type of surgery: Property Property Date of surgery: 12/1/23 Allergies if any: NEDD On room air / oxygen: Popularity IV, fluids on flow: IV F NS - 3000 New Symptoms in last shift:
ASSESSMENT Vital Signs: Temp: 16 (°F) Pulse / HR: 60 (beats/min) Respiration: 2-3 (breaths/min) BP: 12 8 3 (mmHg) SpO ₂ : 98 (%) Height: 160 (cms) Weight: 655 (kgs) BMI: 615 6 1 cg/ Others: Paln 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: NOR NO Drains:
RECOMMENDATION
Referral doctors:
Pending medications:
Pending medication indent:
Pending lab reports / Investigations:
Critical value alert and its corrections:
Changes in nursing care plan: Yes Mo. If Yes, modified care plan date:
Pending follow-up orders:
Special instructions if any:
Signature Name Emp. No. Date Time
Handover given by O UMA MOHESWORL 0 207 12/1/28 7:50
Handover taken by S. Phase Sham Datha Day 18/101 18/101 180
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44/Male/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 3	1/29	Shift: Morn	ning Devening Night			_
S	NEWS / F Ventilator	s: (AD-D\D) PEWS Score: day: If line day: Right: Left be:		days: -		
В	Allergies On room	ROUND urgery: アロー しんり をif any: ハドカト・ air / oxygen: ア・・の とo	on AIR IV fluids on	gery: 12/01/24 flow: 148 304	: wy orlfa	w
A	Others: Pain Sco Fall Risk Braden S	re: O DPain Scale used Score: Minimal Risk: 23-19 Ulcer Scale for Healing (PUS		t: 155 (kgs) BMI: 1 aker FACES Pain Ratin Risk: 14-13 High Risk: Dressing done: Yes	23. kolugi (n ng Scale by R 12-10∐Sever	e Risk: 9-6
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 da	te:	,	·
		Signature	Name	Emp. No.	Date	Time
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Handover ta		Ø	11. Dazle	000	13/12h	(6)
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44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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Date:	13012	A Shift: Morn	ing ☐Evening ☐N	ght	<u> </u>		
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	S: CAD - D V PEWS Score: O day: - Il line day: Right: - Left be:		GCS: 5 6 6 6 6 6 6 6 6 6	015	•	
В	Allergies i	ROUND urgery: PCI し よみり if any: NK DA air / oxygen: RA nts / New Symptoms in last sl	, ľ	. · Date of surg	ery:1211124 ow: -		
A	BP: 10 (Others : Pain Sco Fall Risk Braden S	ns: Temp (C (F) Pulse of the line of t	- (%) Height: 160 (cm 	ns) Weight:	er FACES Pain Ratin	23-6K9/ ng Scale / NHR 12-10∐Severe	CPOT
R	Referral of Pending Pending Pending Critical values Changes	medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes follow-up orders:	1 -				;
•		Signature	Name		Emp. No.	Date	Time
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Mr. KANNAN GOVINDHAN 44/Male/MHJ202481768 12/01/2024/1PH2024000099

Dr.G. GNANAVELU





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

Date: 14	1)54	Shift More	ning Evening I	Night'	*	į	
S	NEWS / F Ventilator Periphera Ryle's Tul Urinary C	s: CA-D < D ✓ D ✓ D ✓ D ✓ D ✓ D ✓ D ✓ D ✓ D ✓		GCS:15/1 POD: — Central line of VIP Score: Specify organis	ols.		,
В	Allergies On room	ROUND Ligery: PTCA to CAD if any: NICDA air / oxygen: On RA ats / New Symptoms in last s		Date o f surg o	ow: _		_
Α	Others : Pain Sco Fall Risk Braden S	re: DO Pain Scale used Score: DO Fall Risk Pr Score: DM Risk: 23-19 [Ulcer Scale for Healing (PU	I: PIPPS / CRIES / FLAC otocol: ☐ Low☐ Medi ☐ At Risk-Mild Risk: 18-15	C / Wong-Bak um ☑ High □ Moderate Ris	ker FACES Pain Rati sk: 14-13 □ High Risk Dressing done: ⊡ Ye	ing Scale / NR	,
R	Pending Pending Pending Critical va Changes Pending	imendation doctors: medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes follow-up orders: instructions if any:	\sim	care plan daté): <u> </u>		1
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NURSES PROGRESS NOTES								
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ADULT NURSING CARE PLAN

MT.KANNAN GOVINDHAN 44/Malc/MHI202481768 12/01/2024/IPH2024000099 Dr.G. GNANAVELU



Every heart beat counts

			<u> </u>	
Initial Date: 12[(/2	Time: 8200	Modified Date: Time:		<u></u>
Reason for Modification:		Diagnosis: AD DUI	<u> </u>	
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	Patient-had NDO F pt had @ diet N pt had @ diet	Ofm
OXYGENATION Reom 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 proteint pan foom E Pt On Room out N pton rooms si	one o
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 Chart Moniford E EVE N'S - 30 cells N JUP NS - 30 cells A Moniford	District Contract of the contr

Patient Specific Sign & Measurable Goals Nursing Interventions Evaluation Problems / Needs Initials MOBILITY Patient will mobilize freely ☐ Encourage regular ambulation ROM exercise Mobile / Immobile ☐ Patient will perform physical Apply Anti-Embolic stocking / SCD Malk with assistance activity independently or within Evaluate the need for assistive devices. limits of disease ☐ Physiotherapy Assess the safety of the environment ☐ Others: ☐ Consider the need for home assistance ☐ Patient will use safety measures to minimize potential for injury mobilized (e.g., physical therapy, visiting nurse) Patient will demonstrate the use of ■ Note for progressing thrombophlebitis adaptive devices to increase mobility (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature) will boobilize ELIMINATION Patient will have normal elimination. ☐ Encourage fluid intake Catheter, bedoan, urinal ☐ Encourage fibre diet intake ☐ Nasogastric tube ☐ Patient will control of urinary ☐ Encourage early ambulation Bowel movement Urination in-continence or urinary retention, ☐ Report any abnormalities to physician control of bowel incontinence, ☐ Observe voiding accessories as foley's / Others: and regular elimination patterns silicone catheter ☐ Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention SKININTEGRITY Patient will maintain normal ☐ Minimize / Eliminate friction and shear ☐ Maintain normal skin integrity healing status ☐ Minimize pressure (off-loading) with special beds Pressure points site ☐ Make sure wrinkles free bed / comfort surfaces ☐ Patient will discharge with intact assessment skin integrity and devices ☐ HAPI ☐ OPI ☐ Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin **GRADES OF PRESSURE** INJURY Maintain adequate nutrition and hydration ☐ GRADE 1 ☐ GRADE 2 ☐ Proper application of medications and dressing ☐ GRADE 3 ☐ GRADE 4 ☐ Follow doctors and TVN order properly ☐ Unstageable ☐ Monitor the healing status Deep Tissue Injury ☐ Educate patient and family members about further ☐ Healing Status skin care PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis pt mointained @_ String ntegority ☐ Pressure injury / blisters site care given Others:

		-		
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	Matient well groom	h l
SAFETY Sheck ID Hand Vere 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)	My burd prosent E ID bound proceed N pt 20 85ml present	Fee 6
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	
OBSERVATION ☐ Vital Signs ☐ GCS ☐ Blood Sugar ☐ Others:	Patient will have normal range of vital parameters	Moritor 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	Mital Digits Chelond & Pelorde E Vitals Chelos Recorted N DA VIHIS do Map E recorded	Box o
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 Chological & por E prychological sep Given N Pychological spoot	Pel DOHO

i jobicina / itt	ic	Measurable Goals	Nursing Interventions	Evaluation	Si Ini
COMMUNICA Verbat Non-verbal Sigh language Others:		Patient will communicate effecti with positive feedback	vely Introduce the care giver Encourage the use of call bell Obtain interpreter if needed No negative speaking about the patient's condition or prognosis in the patient's presence		cotion !
;				N Pt vitts char	revoral of
SPECIAL INTO Medication Wound care Isolation Ostomy Care Blood / Blood transfusion Fluid tapping DVT Managem Others:	products	☐ To manage on time	 □ Double check for high alert medication □ Observe and report any medication 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 blood products and fluids □ Monitor DVT score and continue treatment as per doctors order 	E medicine of as per o	gruen (Ven g hrugels o
<u>·</u>	Signature	Name	Emp. ID	Per ch	Time
Endorsed by	Jay		AMADERS ()	90- B/1	129 10
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ADULT NURSING CARE PLAN

Mr.KANNAN GOVINDHAN

44/Male/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





Initial Date: 12/1/24 Time: //LJO Modified Date: Time: TAD - DUD Diagnosis: Reason for Modification: Patient Specific Sign & **Nursing Interventions Measurable Goals** Evaluation Problems / Needs Initials NUTRITION Patient will have adequate nutrition Provide Prescribed dlet on time with no nausea and vomiting ☐ Encourage patient to consume the served meal ☐ Keep NPO Regular Diet ☐ Patient will consume daily nutritional Record amount of food consumed Others: requirements in accordance to his activity level and metabolic needs OXYGENATION ☐ Patient will have normal O₂ saturation TEncourage chest physio / deep breathing and Patient ABG levels will return to and ☐ Room Air coughing exercise / Spirometry exercises M ☐ Nasal Cannula / High Flow O. remain within normal limits Provide well-ventilated environment / respiratory ☐ Mask medications / Oxygen as per doctors order ☐ No other respiratory abnormalities ☐ BIPAP / CPAP Patient respiratory rate will remains ☐ Utilise pulse oximetry to check O₂ saturation and pulse rate ☐ Ventilator ☐ If any O₂ abnormalities detected inform immediately to within established limits ☐ Tracheostomy ☐ Patient will indicates, either verbally the concerned physician Others: ☐ Place patient with proper body alignment for maximum or through behavior, feeling Ε breathing pattern comfortable when breathing Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis Note for changes in level of consciousness Send sputum for culture and sensitivity based on physician order ☐ Maintain clear airway by suctioning or encouraging N Short GBUE patient with successful coughing ☐ Enhance fluid intake unless restricted FLUID & ELECTROLYTES Patient will have balanced fluid and Î ∩ Oral electrolytes balance ☐ Check IV sites and assess if there is any complication ☐ Intravenous Provide tube feedings ☐ Enteral Nutrition ☐ Monitor intake and output Parenteral Nutrition Measure or estimate fluid losses from all sources such Others: as diaphoresis, wound drainage, and gastric losses ■ Monitor for possible sources of fluid loss ☐ Monitor BP for orthostatic changes N 2/0 chust cry

Patient Specific Sign & **Nursing Interventions** Measurable Goals Evaluation Problems / Needs Initials ~ MOBILITY Patient will mobilize freely Encourage regular ambulation ROM exercise ☐ Mobile / Immobile Patient will perform physical Apply Anti-Embolic stocking / SCD М ☐ Walk with assistance activity independently or within Evaluate the need for assistive devices Physiotherapy limits of disease Assess the safety of the environment ☐ Others: ☐ Patient will use safety measures Consider the need for home assistance to minimize potential for injury (e.g., physical therapy, visiting nurse) Patient will demonstrate the use of ☐ Note for progressing thrombophlebitis Ε adaptive devices to increase mobility (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature) N pt moh! Arod **ELIMINATION** Patient will have normal elimination Encourage fluid intake Catheter, bedpan, urinal pattern Encourage fibre diet intake M ☐ Nasogastric tube Patient will control of urinary Encourage early ambulation ☐ Bowel movement in-continence or urinary retention, Report any abnormalities to physician Urination ☐ Observe voiding accessories as foley's / control of bowel incontinence, ☐ Others: and regular elimination patterns silicone catheter Check placement before feeding Ε Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention SKIN INTEGRITY Minimize / Eliminate friction and shear Patient will maintain normal ☐ Maintain normal skin integrity healing status ☐ Minimize pressure (off-loading) with special beds ☐ Pressure points site Patient will discharge with intact ☐ Make sure wrinkles free bed / comfort surfaces М and devices assessment skin integrity ☐ HAPI ☐ OPI Early skin inspection and treatment ☐ Keep position changing 2 hourly and manage pain ☐ Manage moisture, clean and dry skin☐ Maintain adequate nutrition and hydration **GRADES OF PRESSURE** INJURY ☐ GRADE 1 ☐ GRADE 2 Proper application of medications and dressing ☐ GRADE 3 ☐ GRADE 4 ☐ Follow doctors and TVN order properly Unstageable ☐ Monitor the healing status Ε ☐ Deep Tissue Injury ☐ Educate patient and family members about further ☐ Healing Status skin care ☐ PUSH Decreased ☐ PUSH Increased ☐ Intermittent Assisted ☐ Dermatitis Pressure injury / blisters site care given Ν Others:

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE Bed-Bath Assist-Bath Self-Care CBD Care (if present) Others:	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs Patient will recognize individual weakness or needs	Encourage patient to do daily bathing and oral hygiene Change patient's gown daily Encourage hand hygiene Consider the patient's need for assistive devices Apply moisturizing solution	M E	
			N PA GROONS	Tans
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	
CENTRAL LINE Side rails Others:	ļ	☐ 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 ED herd	The
COMFORT AND SLEEP Pain Control Sleep Patterns	Patient will have comfortable sleep Patient will verbalize / or through	Provide clean calm and restful environment Provide privacy at all time	М	
☑ Steep Patterns ☑ Others:	behavior about pain relief and adequate sleep	Monitor pain scale / sleep pattern Provide pharmacological and non-pharmacological therapy	E	
		· . · ·	NA Sleep, well	<u></u> .
OBSERVATION Vital Signs GCS	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality	M	
☐ Blood Sugar ☐ Others:		☐ Inform doctor if there is any abnormality ☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	E	
			No stel ceg	SOIN
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs Bollete / Volume / Customer	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☐ Firely to the patient of the patients of the patient to pray ☐ Pray or encourage the patient to pr	М	
Bellefs / 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	<u> </u>

- Patient Specific ં Sian &ં Measurable Goals Nursing Interventions but whethis processed is Problems / Needs #Initials િIntroduce the care giverમાલ્ય પ્રાથમિક સ્ટર્ટા લેં COMMUNICATION - Macha yare how though fill FULL STATE Patient will communicate effectively M contract New ☐ Encourage the use of call bell a cone → ☐ ☐ Obtain interpreter if needed to be be > ☐ #254.08 [] ☐ Verbal with positive feedback الإرجادة الكاعدة 5 to March in his in Non-verbali ☐ Sigh language 83 No negative speaking about the patient's condition have ran i le from Gregoriann 05.1.160 950 Back E-21-32-13 (5)-54 Others: or prognosis in the patient's presence disease inte 27 52 12 30 1640 - 11 4 N Pt commonizate 1,4 To manage on time SPECIAL INTERVENTIONS क्रका दक्ष अपनुक्ति । क्रान्ति औड^{दि} Double check for high alert medication . . . no natag 73.93% is Medication Observe and report any medication reaction 2.10a€ £c ☐ Wound care ☐ Provide proper measures of wound care 20.1 a 1, ju BG 160 ☐ Isolation ☐ Follow hospital polices and protocols of isolation Ostomy Care and explain to the patient / family and see el mala m ☐ Check for cross matching and typing: to ensure ☐ Blood / Blood products 135 D Ε transfusion compatibility and sense of the ☐ Fluid tappina Practice strict asepsis while transfusing blood or DVT Management blood products and fluids Others: Monitor DVT score and continue treatment. as per doctors order Logical Annual Company of the MERCES FRANCES SERVICE 1 3 1 3 2 1 5 C C C 1 3 1 5 1 5 1 7 9 10 Ex. 8 48 187 . st. com Signature Name Emp. ID 1 1 8 6, 6 % Time and to Clarific with Chickers Date Nalini 9:00 002 Endorsed by any Early send palebin no propiets, virotical (1) of violational armones Marmards yes miless are a weat-! 300 miora codo deservir amentados moine de Four models gardf 5 Jos and 2000 attrob COU beauty, to educationly to brain of the abort amonated as 3 3. Regula, Mediculation of the more appearance or the faction is agree on the fact to TOGA NEW MARK SHOPPING THE WAY, THE PSYCHAROCETAL 11 impi vilanama kalesian 1 🛄 mini transports of Maine My inches. CHORILLA SALTRONY fill Reliable and subject and each it into adding reserve air hau incour aus · 在于900年前1987年) the recommendation that he are the CONTRACTOR TO TO BE SOME PARKET I Encourage we belowing in the speak of the round or touch psychology in person. Sharry and Workin Page 3.5 Hoot N Stresson En Provide emplatry and realismence aror#C[] Ų.





ADULT NURSING CARE PLAN

MT.KANNAN GOVINDHAN

44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





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Initial Date: ולולו	, Time: 8ເວ	Modified Date: Time:		
Reason for Modification:	•	Diagnosis: (AD-DVD		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION Keep NPO Regular Diet Others:	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional requirements in accordance to his	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	E patent had hunch.	Ross.
	activity level and metabolic needs		N patient had Wdiet	11.7.
OXYGENATION Room Air Nasal Cannula / High Flow O, Mask BiPAP / CPAP	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	N 6+ ON 600W #18	8021
☐ Tracheostomy ☐ Others:	Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	the concerned physician Place patient with proper body alignment for maximum breathing pattern Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis Note for changes in level of consciousness	E Spor mauritained	8041
· .		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	Patient us on noom and	Mg/ 05/25
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition	☐-Patient will have balanced fluid and electrolytes balance	Enhance fluid intake unless restricted Check IV sites and assess if there is any complication Provide tube feedings Monitor intake and output	M P+ NE 30 cc/mc onfo	A STEN
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 Patient fluid status balanced	PO211
	,	The manager of the state of the	N Ilo chart mondora	045

Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment	position bed no +9 m	No.
☐ Others:	 □ P∴tient will use safety measures to minimize potential for injury □ Patient will demonstrate the use of adaptive devices to increase mobility 	 ☐ Consider the need for home assistance (e.g., physical therapy, visiting nurse) ☐ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature) 	e patient was	800
			N PE Slowly mobilized	Mil
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 R+ @ oumination	A
☐ Officiation	and regular elimination patterns	silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	E climination patter	3
	, , , , , , , , , , , , , , , , , , , ,	and follow proper protocol Check for malena / constipation / urinary retention	N Normal Elimination Pattorn	MIL
SKIN INTEGRITY Maintain normal skin integrit Pressure points site assessment HAPI OPI GRADES OF PRESSURE	Patient will maintain normal healing status; Patient will discharge with intact skin integrity		M P+ Maintain (1) Skin witagenty	8 01
INJURY ☐ GRADE 1 ☐ GRADE 2 ☐ GRADE 3 ☐ GRADE 4 ☐ Unstageable ☐ Deep Tissue Injury ☐ Healing Status ☐ PUSH Decreased ☐ PUSH Increased			Maintenned E Dkin intogrity	821
☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			Maintain normal N skin intact	Hil

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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 Cloon & will genomed E patient etem Cleaned N Pt 4000 hygiene	Stock Hay
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 R+ ID band Prosent E ID Band Prosent	Non.
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 Pr Provide Confortable E provided privary N Provide Confort	Soul Hotel
OBSERVATION Vital Signs GCS Blood Sugar Others:	☐ Petient 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 P+ VIS chacked & Journal Perioded E Mitall estable. Notal Signs Chackers.	802 S
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 splritual needs as they arise Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	m Provide Psychological E Provided E Psychological Se N	Sony

Patient Specific Problems / Needs	Measurable Goals		Nursing Interventions	Nursing Interventions			Sign & Initials
COMMUNICATION Verbal Non-verbal Sigh language Others:	/erbal with positive feedback Non-verbal Sigh language		☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patient's condition or prognosis in the patient's presence		M Pt 40001 N Pt 40001 Communication will		\$ 65.11 \$ 65.11
SPECIAL INTERVENTION Medication Wound care Isolation Ostomy Care Blood / Blood products transfusion Fluid tapping DVT Management Others:	S To manage on time		Doùble check for high alert medication Observe and report any medication react Provide proper measures of wound care Follow hospital polices and protocols of i and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing be blood products and fluids Monitor DVT score and continue treatments as per doctors order	solation ensure slood or	M P+ Which E medicati as pose N Hodicati	tion given cel Observation	80211
, Signatur	9 ,	Name		Emp. ID	,	Date	Time
Endorsed by Jac	1	JA	(fregary)	<i>00</i> 2\		13/1/24	1000
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ADULT NURSING CARE PLAN



				
Initial Date: 나니기94	Time: 8.00	Modified Date: Time:		
Reason for Modification:		Diagnosis: CAD-DUD		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO ☐ Regular Diet	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	M pl on (1) byet	Osí stat
Others:	requirements in accordance to his activity level and metabolic needs		E	
			N	
OXYGENATION Room Air Nasal Cannula / High Flow O ₂ Mask BIPAP / CPAP	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	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 O ₂ saturation and pulse rate	M PHON ROOM Air	() () () () () () () () () ()
☐ Ventilator ☐ Tracheostomy ☐ Others:	within established limits Patient will indicates, either verbally or through behavior, feeling comfortable when breathing	☐ If any O₂ abnormalities detected inform immediately to the concerned physician ☐ Place patient with proper body alignment for maximum breathing pattern ☐ Evaluate skin colour, temperature, capillary refill and central venous peripheral cyanosis	E	
		 Note for changes in level of consciousness Send sputum for culture and sensitivity based on physician order Maintain clear airway by suctioning or encouraging patient with successful coughing 	N	
FLUID & ELECTROLYTES Oral Intravenous Enteral Nutrition	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 Dlo chart maintained	(la)
Parenteral Nutrition Others:			E	
		- Monney 2. 101 Oranostatio Granigos	N	

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Patient Spe Problems /		Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
MOBILITY Mebrite / Im Walk with a Physiothera Others:	ssistance	Patient will mobilize freely Patient will perform physical activity independently or within limits of disease Putient will use safety measures	Encourage regular ambulation ROM exercise Apply Anti-Embolic stocking / SCD Evaluate the need for assistive devices Assess the safety of the environment Consider the need for home assistance	mpt valel/ mobiline	Ost Gar
		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	
ELIMINATI Catheter, be Nasogastric Bowel move	edpan, urinal c tube	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 Pt self voided	Of Olas
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	Е	
			Check for malena / constipation / urinary retention	N	
☐ Pressure po assessmen ☐ HAPI ☐ GRADES O	rmal skin integrity onto	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 (N) M Skin Intrad-	(By'
INJURY GRADE 1 GRADE 3 Unstageabl Deep Tissue Healing Sta PUSH Decre	☐ GRADE 4 e Injury tus eased ased			E	•
☐ Intermittent☐ Dermatitis☐ Pressure injcare given☐ Others:	Assisted ury / blisters site			N	

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

*

N	Dationt will communic						Initials
COMMUNICATION Verbal Non-verbal Sigh language Others:		cate effectively k		Encourage the use of call bell		tell mmumcated	(a) o las
			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 and explain to the patient / family Check for cross matching and typing, to ensure compatibility Practice strict asepsis while transfusing blood or				
	☐ 70 manage on time				Due medical A'or		GI
			☐ Monitor DVT score and continu as per doctors order	treatment	N		
gnature		Name		Emp. ID		Date	Time
Nul		S'	NalPAP	1	0020	Itel 1 loca	6-662
	ENTIONS	ducts	ignature Name	entrions Double check for high alert med	ENTIONS 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 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 Monitor DVT score and continue treatment as per doctors order Name Emp. ID	or prognosis in the patient's presence E N ENTIONS 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 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 Monitor DVT score and continue treatment as per doctors order N Ignature Name Emp. ID	and explain to the patient's presence Compatibility Practice strict asepsis while transfusing blood or blood products and fluids Monitor DVT score and continue treatment as per doctors order Monitor DVT

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44/Male/MHi202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





Every heart beat counts

Date: 12

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK Time:		N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort, or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort		4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals		4
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours		H
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		FT
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein(meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation		4
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3 No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. No or chair			3
& SHEAR	slides down in bed or chair, requiring frequent re-positioning with maximum	chair, restraints or other devices. Maintains relatively good position in chair		TOTAL SCORE		7-2
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & Emp. No. of Staff Nurse:		FQ.
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:		ععا





44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





Every heart beat counts-12

Date:

	BRADEN S	CALE FOR PREDICTI	NG PRESSURE INJUR	Y RISK Date:	W .	10	2.0
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	commands. Has no sensory	<i>T</i> 1	4	H
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4. Barely Moist Skin is usually dry, linen only requires changing at routine intervals	11	Å	.4
	Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4 Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	4	本	1
MOBILITY ability to change and control body position	Completely immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	A: 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	Never refuses a meal.	φ	F	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	chair, restraints or other devices.	3 No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. It or chair		2		3 532
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:	2	2	2





44/Male/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





Every heart beat counts

Date: 13

	BRADEN S	CALE FOR PREDICTION	NG PRESSURE INJUR	Y RISK Time	m	ि	x/.
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 Besponds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	1	4	4
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4) Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4	4
	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	١.	1	1
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance		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. Altequate 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	3
FRICTION	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets,	3. No Apparent Problem Moves in bed and in chair independent strength to lift up completely during move. It or chair		ζ.	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		TOTAL SCORE	17	18	18
	agitation leads to almost constant friction	slides down		Initial & Emp. No. of Staff Nurse:	A SOL	3	170x
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:		Will	Win

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK





44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





Every heart beat counts

Date:

	BRADEN S	CALE FOR PREDICTII	NG PRESSURE INJUR	Y RISK Time:	14 I	E	N
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	A. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	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	9. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	34		
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	Ţ		
MOBILITY ability to change and control body position	Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4 No Limitation Makes major and frequent changes in position without assistance	*		
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or diary products per day. Occasionally will take a dietary supplement	4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement	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	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair	3 No Apparent Problem Moves in bed and in chair independent strength to lift up completely during move. Nor chair	Maintains good position in bed	3		
	assistance. Spasticity, contractures or agitation leads to almost constant friction	or bed most of the time but occasionally slides down		Initial & Emp. No.	000 B		
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:	Mary		*







44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





PAI	N RI	E-ASSESSMENT	& MC	NITORING	CHART			Every heart l	eat counts
Date &	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	_	Interventions	W. S.	Staff Initial & Emp. No:	Senior Staff Initial & Emp. No.
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,	also	100 pin	•	-				CANI	Naca.
1000	0/10	No pain	-					Pap	100 10024
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16:00	o/v	No pais	-					0200	Joffer
14:201	, 0 [w	No paris					·	De Coc	Jufat
[8-70F	Olu	No pais	_					D (O Dut) seyfour
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∞;a>	%	No Ps, S	_					low c	09

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		tep .		_	
Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
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No Pain	•	_		S S	pologo
No psi	_	~		0 8 C	lacy good
No priù	c	C		oros	Joy or
,	·	PA	IN SCALES		
7 - 12 = Mild pain - Provid	de comfort me		n .		
				4,	
I O' RAISYAG & comtortable	e, 1-3: Mild d	iscomfort, 4-6: Mode	rate discomfort, 7-10: Severe discomfort / pain / both		
cale	(96) Hurts Little More	6 Hurts Even More	8 10 0 1 2 3 4 5 10 10 10 10 10 10 10 10 10 10 10 10 10	 	9 10
BODY MOVEMENTS: 0 - COMPLIANCE WITH VEI VOCALIZATION (non-int MUSCLE TENSION: 0 - F	Absence of m NTILATION (I ubated paties Relaxed, 1 - Te	novements or normal p ntubated patients): 0 nts): 0 - Talking on nor ense, Rigid, 2 - Very Te	osition, 1 - Protection, 2 - Restlessness / Agitation - Tolerating Ventilator or Movement , 1 - Coughing but tolerating, 2 - Fightin mal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing nse, Rigid	g ventilator (or)	
orical Cutaneous Stimulation a	ınd massage	: E - Positioning; F - Ru	bbing / Massage the skin		
	(dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain) No Psi No	(dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain) No PSI No	Counting Composition Counting Counti	Coult Country Starp Stabbing Shorting Duration Durat	Coult Country State Country Country



PAIN RE-ASSESSMENT & MONITORING CHART

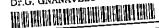




Mr.Kannan Govindhan

44/Male/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU



MHI/NUR/2022/052



Every heart beat counts

Date & Time	Pain Score	Pain Character (dúll, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial	Senlor Staff Initial & Emp. No.
12/124 01:00	0/10	i No Proc				or or	Jack
0200	0/10	so pri	-	• •-	Transfer of	De dons	Joylood
03:00	o/w	aro psi-	-	<u> </u>		e our	Jalfor
04:00	0/10	No psi-	_		<u></u>	Q .	July of
H:50	र्भा०	Achy	30 m/s	Herd Brek	en physomecological achoi	om o	alsoce
05,00	1/10	Dull	- Bopen LS	<i>3</i> }	or prometogical action	Oz (Tayou
) (j.po	0/10	No prin	_			One.	Jeey ou
12.00	0/10	No Psin	_			024	Toyon
K C! 0 0	10 (bc	to four	~ _			OLY.	lay son



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Date & Time	Pain Score	(dull, achy,	Pain Character ly, sharp, stabbing, shooting, ng, referred / radiant pain) Location /					Site	Interventions									taff In Emp.		Init	r Staff al & . No.			
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10100	Olio	N	No sain			•	-											8	اللار	Joh	av			
11.00	oho	N	b	pair)		-		,	·		 -				_					\$	Ŋ)ay	00/
12:00	Olio	N	al	par)		_			·											860	<u>ئ</u> ا.) O	box
	•	`				-	1	PAIN	N SC	ALES														•
(28 week	PIPPS s to <u><</u> 38	3 weeks)	7 - 12		n - Provid	de comfort m	easures mocological inter	vention													r			
(38 we	CRIES eks - 2 m	onths)					> than or = 38 w indertaken, and a											scor	e is >	4,				
	ACC Sca	_	0: Rel	axed & coi	nfortabl	e, 1-3: Mild	discomfort, 4-6: I	Moderate	e disco	mfort, 7-	10: Sev	ere di	scomf	ort / p	aln / b	oth								
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)		(S.)		2 Hurta Little Bit	(©) 4 Hurts Littl More	6 Hunts	8 Hun Whole	5 3	10			Nu O None	ımer	ical F	Rating 3	Sca 4		Ē	nore	than	12 y	years 9	10 10	
Observat	cal care F tion Tool tor / com	(CPOT)	BODY COMI VOCA MUSC	/ MOVEME PLIANCE W ALIZATION CLE TENSION	NTS: 0 - /ITH VEI (non-int ON: 0 - F	Absence of NTILATION (ubated patie)	leutral, 1 - Tense, movements or nor (Intubated patlen ents): 0 - Talking o ense, Rigid, 2 - Ve Moderate Pain; 5 -	rmal posi its): 0 - To on norma ery Tense	sition, 1 folerating al tone d e, Rigid	g Ventilat or no sou	tor or Me	oveme	sness	Coug	hing b			2-F	1	yent	ilator (`		
•	narmacolo ervention	- 1	Cutan	eous Stim nai.Therapi	u <mark>lation</mark> a les (no lo	i nd massag onger than 19	environment; B - e: E - Positioning; 5 to 20 minutes): 0 nulation (TENS): 0	F - Rubb G - Cold :	bing / M applica	assage tl tion; H - I	he skin Hot app	lication	n; I - St	nortwa	ve diat ounse	hermy I ling: K	(- Ind	ividua	al Cour	nselin	g; L - F	amily	counse	eling ,
Pharmaco	ological i	ntervention	s as pe	r doctor's	prescrip	tion				,		-		,	-									





44/Male/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU

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MHI/NUR/2022/052



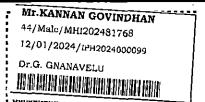
Every heart beat counts

PAIN RE-ASSESSMENT & MONITORING CHART

<u> </u>						,	
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.
18/1/29	61.	0	•	,		&h-vi	Jack X
13,00	-/10	Mo Bain				िक्रा	100/001
W100	oho	No pain	•			SI	Jac 1000
lswo	oho	No pain	·			8	Jaylow
16:00	010	No Pour	F .			Po II	Jack Joen
20.00	0/10	NO Pain	- -	-	_	H	Noof
ru/1/221 00.00			Pat	iont sleep	\$4000		
7.00	olio	uo pain	۲			Chy Ota	Neger
8,00	0/60	rlo pain	←			Confer	Naf

Date & Time	Pain Score	(dull, achy	Pain Character , sharp, stabbing, shooting, g, referred / radiant pain)	Duration	Location / Site		Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.					
									_					
J	·		···											
,		ţ												
		r	,					7.00	·					
		•			P/	AIN SCALES								
(28 week	PIPPS (s to <u><</u> 38	weeks)	6 or less = Minimal to no 7 - 12 = Mild pain - Provid >12 = Moderate to sever	de comfort me	easures nocological interventi		',							
(38 we	CRIES eks - 2 ma	onths)		The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, urther pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.										
	ACC Scal		0: Relaxed & comfortable	e, 1-3: Mild d	Iscomfort, 4-6: Mode	erate discomfort, 7-10: Severe	a discomfort / pain / both	;						
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)		ale	O 2 No Hurts Little Bit	4 Hurts Little More	6 Hurts Even More	8 10 Hurts Whole Lot Worst	Numerical Rating Scale (age m 0 1 2 3 4 5 6 None Mild Moderate	7 8	9 10					
Observa	cal care P tion Tool ator / com	(CPOT)	BODY MOVEMENTS: 0 - COMPLIANCE WITH VEI VOCALIZATION (non-int MUSCLE TENSION: 0 - F	EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing OVEMENTS: 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation ANCE WITH VENTILATION (Intubated patients): 0 - Tolerating Ventilator or Movement, 1 - Coughing but tolerating, 2 - Fighting ventication (non-intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid CORE: 0 - 2: No Pain: 3 - 4: Moderate Pain: 5 - 8: Severe Pain										
	harmacolo tervention		Cutaneous Stimulation a Thermal.Theraples (no lo	i <mark>nd massage</mark> inger than 15	: E - Positioning; F - R to 20 minutes): G - C	- Music; D - Physical and menubling / Massage the skinold application; H - Hot applicaterferntial therapy Psycho-se		seling; L - Family	r counseling					
Dharman	ological li	sterventlo	ns as per doctor's prescrip	tion			,							







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

		1 - 1						
	Date	12/1/20	13/129	14/124				
	Time	2 300	3.00	7.00	_			· <u> </u>
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	10	0	0				
2	Bedridden recently >3 days or major surgery within four weeks	0	0	0				
3 .	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0		x		
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	<i>©</i>	Ŋ	0_	· 		<u> </u>	
5	Entire leg swollen (Assess for both legs)	e e				<u>.</u>		l
6	Localized tenderness along the deep venous system (Assess for both legs)	0	0	0				
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0	0	0		<u> </u>		
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	0	0	0			•	
9	Previously documented DVT (Assess for both legs)	Q	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.	Q	0	0			2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
	FINAL SCORE	0	O	0				
Low R	isk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	pw	/ovo	2000		_		
	DVT prophylaxis started	□ Yes □ No	□ Yes □ No	☐ Yes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Signature & Emp. No. of RN	COSIN	· Sans	Yes	,			
	Signature & Emp. No. of Sr. RN	Day.	d	Was				



Medway Hospitals

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

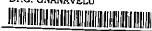


Mr.KANNAN GOVINDHAN

Patie: 44/Malc/MHI202481768

Name 12/01/2024/IPH2024000099

UHID Dr.G. GNANAVELU





MODIFIED MORSE FALL RISK ASSESSMENT CHART

L			i			T/ a		6 1	I.	T	
	Variables	Date	12/1/25	12/1/2	12/12	412/1/25	12/1/24	13/1/2	13/124	1धी १३५	
	,	Time	2720	2.00	16:01	90.4°	8:00	18-40	20.00	g. 60	
	History of falling	No	•	4	0/	0	(b)	6	10	0	0
	(immediate or within 6 months)	Yes	25	25	25	25	25	25	25	25	25
	Secondary diagnosis	No	0	O	0	0	0	0	0	0	0
	(≥ 2 medical diagnosis)	Yes	15	15	15	15	(/15)	(15)	145	√15	15
	Intravenous Therapy /	No	.8	0	0	0 (0	0	0	0	0
	Heparin Lock / Tubes Insitu	Yes	20	20	20	20	(20)	(20)	120	/2 0	20
7	AMBULATORY AID						^	(
l	None / Bed Rest / Nurse Assist		م	0	9	ø	(0)	$\binom{\circ}{}$	Lor	187	0
	Crutches / Cane / Walker		15	15	15	15)5	15	15	15	15
L	Furniture .		30	30	30	30	30	30	30	30	30
Ì	GAIT					~	0], _		
L	Normal / Bed Rest / Wheel Chair		_0_	0	Ø	0	(0)	(0)	Lo	40	0
L	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_	6	9/	(0)	(0)	10	\d	0
5	Overestimated or forgets limitations		15 ·	15	15	15	15	15	15	15	15
	MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives,	No	X	. •0	.0	_0/	0	0	0	0	0
	immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	Yes	15	15	15	15	(15)	15	15	15	15
l	Total Score		50	35	50	4	50	\$200	50	50	
	Low Risk (0 - 24)										
	Medium Risk (25 - 44)		/		,						
	High Risk (45 or above)					-/	/	V	~		
Ī	Signature & Emp, No. of RN		& an	1819	Provi	0/1/10	San	SPAI	FALL	Of ar	
	Signature & Emp. No. of Sr. RN	;	Nag-	Mar	M/	100	an.	Di	Me D	V24	
	No. 1	()	0 -	24: Low	Risk; 2		ledium	Risk; 45	or abo	ve: High	Risk

		1 10	, <u> </u>	- Co.	1			*	-	-
INTERVENTIONS	Date	Whish	12/1	13/1/	1/1/2	13/124	13/19	ध्यारिय	14 9:	. ; ; ; ;
Tick as per the Risk Score	Time	270		, 10, 0	90°	8.00	14.0	2000	200	٠,
Low Risk Interventions (0 - 24)				, /	, ,					
Familiarize the patient with the immediate surroundi	ings									
Remind the patient to use call bell before getting out	of bed							\		
Keep the two side rails in the raised position at all ti	mes for			- /				-		
all patients regardless of age					_<		_/		V	
Keep the call bell, bedside table, water, glasses wi patient's easy reach	thin the			_ /				V	<u> </u>	
Remove excess equipment or furniture to make path	a clear	./-		/	/		, /	1	/	
Keep the patient's bed in the low position at all times	event				- -		_			
during procedure	except		/			レー				
Teach fall-prevention techniques, such as sitting to	in for a									
moment before rising from the bed	10 IOI U			/				1	1	
Bed wheels should be locked								\ \ \		
Encourage family participation in the patient's care					-		-		 	
Ensure that floor of the bathroom is dry and not slipp	perv		,		1		1			
Review medications for potential side effects the	_ <u>-</u> _		- -		-				<u> </u>	
promote falls					 ~∕ ,					
Use safety belts during movement in wheelchair			-		1			1		
The patients are not ambulated by themselves. The	v are to						7	_		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
be ambulated only with assistance	,					1 /			//	•
Medium risk interventions (25 - 44)		<u> </u>								
Apply all the low risk interventions							- U			
Tie yellow fall risk tag in the bed and Wheel chair / St	retcher						1/			·
Make sure that proper transfer precautions are in									,,_	
for heavy or debilitated patients in a bed or wheel		/	•							
on a toilet seat										
Use restraints and bed monitors as ordered by the d	loctor			/		\		-	$\overline{}$	
Allow the patient to ambulate only with assistance										_
Consider peak effects of the medications that effect	ts level			7						
of consciousness, gait and elimination when p	lanning		ı		/			1/		
patient's care		/)		
Do not leave patients unattended in diagno	stic or			/	1	_		1		
treatment areas										
Accompany the patient while going to bathroom							, _/_	د		
Advice the patient to use grab bars near the toilet, b	athtub,			· ./	/				ا <i>ح</i> . ٔ ا	•
and shower										
Make sure the family and other visitors understa	and the			_						
restrictions mentioned above					′					
High-risk interventions (45 or above)					7			_		
Apply all the low and medium risk interventions					<u> </u>					
Tie red fall risk tag in the bed, wheel chair and stretch									\vdash	
Locate the high-risk patients in a room close to the station	nurses		•	1		レ		<u></u>	/_	
Answer these patients call bells as quickly as possib	le			✓.						
Provide a commode at bedside (if appropriate)					1			\checkmark	\mathcal{L}	
Urinal/bedpan should be within easy reach (if appro	priate)		•	رسم				V	✓	
Encourage family members or other visitors to st	tay with			/	1		ANA			
If appropriate, consider using protection devices belts	: safety	,	· S	1		√	1			_
DONG	of BN '	a an	Sec.	(3/g)	0/27b	RQ.	Denall	40,	Di/W	<u> </u>
Signature & Emp. No.	011111					17.75	ロアストドリ	· \\\/	- 211117	
Signature & Emp. No. of Signature & Emp. No. of S		0/	100	777-	X 7	1		59	82	_







44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





PATIENT AND FAMILY EDUCATION RECORD

Barriers to Learning	illy juag	er Je
Limited Reading Abilities Physical barriers Educate fam Religious / Cultural Factors Language barriers Simple Lang Congnitive Limitations - unable to Low motivation / desire to learn Written Instrumentation	uaguctic	ons Signature
Religious / Cultural Factors Language barriers Congnitive Limitations - unable to Understand and follow directions Completed By: Date Time Nurse Signature: Learning Record Need Date Visit 1 Date Visit 2 Date Visit 2 Date Visit 1 Disease Information on Disease / Diagnostics Treatment Medications Information on Safe and Effective use of medicines Information on drug / drug and drug / food interactions	juag	Signature
Congnitive Limitations - unable to Low motivation / desire to learn Written Instrumentation and follow directions Completed By: Date Time Nurse Signature: Learning Record Need Date Visit 1 Date Visit 2 Date Visit 1 P O L P O	i 3	Signature
understand and follow directions Completed By: Date Time Nurse Signature: Learning Record Need Date Visit 1 Date Visit 2 Date Visit 2 Date Visit 1 P O Disease Information on Disease / Diagnostics Treatment Pedications Information on Safe and Effective use of medicines Information on drug / drug and drug / food interactions	13 0	Signature
Completed By: Date Time Nurse Signature: Learning Record Need Date Visit 1 Date Visit 2 Date Visit 1 P O W L P Disease Disease / Diagnostics Disease / Diagnostics Treatment Medications Information on Safe and Effective use of medicines Information on drug / drug and drug / food interactions	0	
Need Date Visit 1 Date Visit 2 Date Visit 3 L P O WHY L P Disease Information on Disease / Diagnostics Treatment Medications Information on Safe and Effective use of medicines Information on drug / drug and drug / food interactions	0	
Need Date Visit 1 Date Visit 2 Date Visit 2 Date Visit 1 L P O VISIT 2 Date Visit 2 Date Visit 3 L P O VISIT 3 Date Visit 4 Date Visit 2 Date Visit 5 Date Visit 5 Date Visit 6 Date Visit 1 Date Visit 2 Date Visit 1 Date Visit 2 Date Visit 1 Date Visit 1 Date Visit 2 Date Visit 1 Date Vis	0	
Need Date Visit 1 Date Visit 2 Date Visit 1 L P O VISIT 2 DATE Visit 2 Disease Disease / Diagnostics Treatment Medications Information on Safe and Effective use of medicines Information on drug / drug and drug / food interactions	0	
L P O ISW L P O W L P Disease Information on Disease / Diagnostics Medications Information on Safe and Effective use of medicines Information on drug / drug and drug / food interactions	0	
Disease Information on Disease / Diagnostics Treatment Medications Information on Safe and Effective use of medicines Information on drug / drug and drug / food interactions		Doctor
Information on Disease / Diagnostics Treatment Medications Information on Safe and Effective use of medicines Information on drug / drug and drug / food interactions		Doctor
Disease / Diagnostics Treatment Medications Information on Safe and Effective use of medicines Information on drug / drug and drug / food interactions		Lusha I
Treatment Medications Information on Safe and Effective use of medicines Information on drug / drug and drug / food interactions	1 /	1 V 'ATT - 1
Medications Information on Safe and Effective use of medicines Information on drug / drug and drug / food interactions	$ rac{\mathbb{Z}}{2}$	1347
Information on Safe and Effective use of medicines Information on drug / drug and drug / food interactions		
Effective use of medicines Information on drug / drug and drug / food interactions		Doctor / Nurse
Effective use of medicines Information on drug / drug and drug / food interactions	1/	DIX 1
drug / food interactions	Ľ	1 20/01/
☐ Discharge Medications		L ſ
<u> </u>	Γ	
Surgical Instructions		Nurse
Pre - Operative Instructions	\bigcup	
Post - Operative Instructions		- AM
(Wound / Dressing Care)		
Pain Management \		Nurse
Reporting of pain P 00 V P 60 V		
Pain Management DOV DOV	\bigcup	Nasy
Safe and effective use of medical		Doctor / Nurse
Equipment (if required)	L	
Name of Equipment		N00
Rehabilitation Techniques		13455

Autritional-Buildance Dist Instruction for patients at Not Distriction for patients at Not Districtio	leed	Date	1	/isit	:1	Date	V	/isit	2	Date	\	/isit	3	Signature
Diet Instruction for patients at Nutritional risk Diet Advice CT Scan Report Diet Advice CT Scan Report Diet Advice CT Scan Report CT Scan Film C			L	Р	0		L	Р	o		L	Р	0	,
Nutritional risk No. Co. Co. Nurse	lutritional Suidance					-						.,	d-	Dietician
Self care Follow up	Diet Instruction for patients at Nutritional risk		1	م	၁		Þ	S.	2		0	مـ ب	Senio V	
Self care Follow up Reporting Concerns Immunizations Parenting education Doctor Doctor Smoking Cessation Doctor	Diet advice for home		<u> </u>				4		П	•				Nursè
Follow up Reporting Concerns Reporting Concerns Reporting education Parenting education Doctor Risk Factor Reduction Doctor Report Risks Reports Given Reports Given Reports Given Reports Given Reports Given Report	Discharge Planning					_								
Reporting Concerns														
Parenting education Doctor Risk Factor Reduction Doctor	Follow up			 								<u> </u>	<u> </u>	
Others														
Risk Factor Reduction Smoking Cessation Doctor Weight Control Exercise Hypertension Other Risks LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other PROCESS (P)- OD - Oral Discussion, D- Demonstration, W- Written Material OUTCOME (O) - RD - Return Demonstration, V - Verbalized Understanding Written Material given and explained (if any) Reports Given: Given Pending NA Diet Advice CT Scan Report CT Scan Film X-Ray Report X-Ray Report X-Ray Film Ultrasound Report Ultrasound Report	Parenting education													_
Smoking Cessation □ Weight Control □ Exercise □ Hypertension □ Other Risks LEARNER (L) - P-Partient, M - Mother, F-Father, S-Spouse Other □ Complete (State Relationship PROCESS (P)- OD - Oral Discussion, D- Demonstration, W- Written Material OUTCOME (O) - RD - Return Demonstration, V - Verbalized Understanding Written Material given and explained (if any) Reports Given: □ Given Pending NA	☐ Others													
Weight Control Exercise Hypertension Other Risks LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other (State Relationshi PROCESS (P)- OD - Øral Discussion, D- Demonstration, W- Written Material OUTCOME (O) - RD - Return Demonstration, V - Verbalized Ønderstanding Written Material given and explained (if any) Reports Given : Given Pending NA Given Pending NA	Risk Factor Reduction												L_	
Exercise Hypertension Other Risks LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other (State Relationship PROCESS (P)- OD - Oral Discussion, D- Demonstration, W- Written Material OUTCOME (O) - RD - Return Demonstration, V - Verbalized Understanding Written Material given and explained (if any) Reports Given : Diet Advice CT Scan Report CT Scan Film C		 		_	L,				Ц			<u> </u>	<u> </u>	Doctor
Hypertension Other Risks CEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other (State Relationship PROCESS (P)- OD - Oral Discussion, D- Demonstration, W- Written Material OUTCOME (O) - RD - Return Demonstration, V - Verbalized Understanding Written Material given and explained (if any) Reports Given Given Pending NA Given Pending NA									Ц					
Other Risks LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other	_	-		<u> </u>					\vdash	-		\vdash	<u> </u>	
LEARNER (L) - P-Patient, M - Mother, F-Father, S-Spouse Other		 	_	 	├-		\vdash		Н	_			<u> </u>	
Reports Given: Given Pending NA Given Pending NA Discharge Summary Diet Advice ECG Report CT Scan Report Doppler Report CT Scan Film X-Ray Report ECHO Report X-Ray Film Ultrasound Report	PROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons	D- Dem tration,	ons	trati	ion,	W- Wri	itter	Ма	teri			(;	Sta	te RelationsI
Reports Given: Given Pending NA Discharge Summary ECG Report Doppler Report X-Ray Report X-Ray Film Given Pending NA Diet Advice CT Scan Report CT Scan Film ECHO Report Ultrasound Report	PROCESS (P)- OD - Øral Discussion, OUTCOME (O) - RD - Return Demonst	D- Dem tration,	ons	trati	ion,	W- Wri	itter	Ма	teri				Sta	te RelationsI
Discharge Summary ECG Report Doppler Report X-Ray Report CT Scan Film ECHO Report Ultrasound Report	PROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Written Material given and explained	D- Dem tration,	ons	trati	ion,	W- Wri	itter	Ма	teri				_	
X-Ray Report ECHO Report X-Ray Film Ultrasound Report	PROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Written Material given and explained	D- Dem tration,	ons	trati	ion,	W- Wri	itter	Ма	teri		- k		_	
X-Ray Film Ultrasound Report	PROCESS (P)- OD - Oral Discussion, OUTCOME (O) - RD - Return Demons Written Material given and explained Reports Given : Given Pendir Discharge Summary	D- Dem tration, (if any)	ons V - \	trati	ion,	W- Write	itter	i Ma	teri	-				: NO
	PROCESS (P)- OD - Øral Discussion, OUTCOME (O) - RD - Return Demons Written Material given and explained Reports Given : Given Pendir ECG Report	D- Dem tration, (if any)	ons V - \	verk	Diet	W- Write Red Who	eport	i Ma	teri	-				: NO
Compact Disk Any Other Report	PROCESS (P)- OD - Øral Discussion, OUTCOME (O) - RD - Return Demons Written Material given and explained Reports Given : Given Pendir Discharge Summary Pendir Doppler Report	D- Dem tration, (if any)	ons V - \	Verb	Diet	Advice Scan Re	eport	i Ma	teri	-				: NO
	PROCESS (P)- OD - Øral Discussion, OUTCOME (O) - RD - Return Demonst Written Material given and explained Reports Given : Given Pendir Discharge Summary ECG Report Doppler Report X-Ray Report	D- Dem tration, (if any)	ons V - \	trati	Diet	Advice Scan Re Scan Fil	eport	Matano	teri	-				: NO
	PROCESS (P)- OD - Øral Discussion, OUTCOME (O) - RD - Return Demons Written Material given and explained Reports Given : Given Pendir Discharge Summary ECG Report Doppler Report X-Ray Report X-Ray Film Compact Disk	D- Dem tration, (if any)	ons V - \	verk	Diet CT : ECH	Advice Scan Re Scan Fil IO Repo	eport m Rep	Ma tand	ding	-		Per	ndi	ng NA



44/Malc/MHI202481768 12/01/2024/tPH2024000099

Dr.G. GNANAVELU





Inter Disciplinary Team Rounds (IDTR) Checklist

Date: (2)(12)(Time:	<u> </u>	<u></u>				
Checklist	Yes	No	NA	Ac	tion / Remarks		
WEDICAL							
Daily Consultant Visit			<u> </u>	<u>. </u>			
Plan of care discussed							
Discharge Planning		,					
Others if any							
NURSING		·				-	
Safety Precautions Ensured							
Care of Lines and Tubes					_	_	
Infection Control Measures		1					
Skin Care		-					
Response to assistance							
Others if any			L				
DÏETICIAN							
Diet Adequate		1					
Special Request							
PHYSIOTHERAPIST							
Available for Assistance for Activities of Daily Living							,
Others if any							
PATIENT CARE SERVICES							
Room Cleaning satisfactory							
Room Amenities Adequate							
Billing Update available							
Non-Availability of any service							
Spiritual Needs (if yes specify)							
Others if any		-					
	-	<u>l</u> r	iter Dis	sciplinary Team Members			
	Signatur			Name	Reg. / Emp. No.	Date	Time
Doctor	r.V	-734	mp_	DR-ANUSUYA	134559	12/1/24	2700
Nursing Staff		<u> </u>		A-monsher	0//2/	2/1/pie	2/201
Dietician	(SH		Maria Cofferm	- rap	12/1/1	صما
Physiotherapist				_			
Patient Care Service Staff						Į.	



44/Male/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU



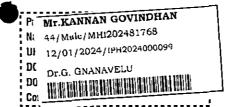


IN-HOUSE TRANSFER FORM

		_						
	Part	A (to be filled by Nui	rses)					Receiving Doctor Yes No Yes Yes No Yes Yes No Yes Yes
	Date	e of Transfer: 13/1/20	Time: <u></u>	m_ Tra	ansferred	from:	√ To:	vay
	Diag	gnosis:	an java	> (36.	\sim	<u> </u>		
	Vital	Signs: Temp: New CE		.91	(beats/n	nin) BP: /39	/ல _ (mmHg) Resp	piration/10 (breaths/min)
٠	· ·	B (to be filled by Phy			al Investig			
Ì		Check for			Trai	nsferring Docto	or	Receiving Doctor
	Resp	iratory (Breath sounds)	elear _	Crepitat	ion 🔲 F	Rhonchi O	thers:	Yes No
	Abdo	men	Soft [Tender			thers:	Yes No
	Hear	Sound	Normal [Feeble	Loud	d Others:_		Yes No
	CNS		Consciou	ıs Or	iented		re:	Yes No
i		ourgical Patients	Surgical Site:	Heal	thy S	oakage 0		Yes No
	"		Prese	nt Medic	ation (for	Medication Re	econciliation)	
	S. No.	Current Medic	ation	Dose	Route	Frequency	Date & Time of last dose	-
	Į-	Th. Ecosp	kin	30	plu	(J)	Fordy"	Yeß □ No
		n-Axcor		904	P/c	15	ابر	☐ Yes ☐ No
		M- Mach		800	- T-		۲	☐ Yes ☐ No
4	-7.	Tr. PUM	pan ~D	112	t		t.	☐ Yes ☐ No
,		T-1- NET 0	<u> ۲</u> ــــــــــــــــــــــــــــــــــــ	257%	2 19	∞	<u> </u>	☐ Yes ☐ No
		THI. N ITLOU	NTN.	2-67	4	ßу		☐ Yes ☐ No
		03- FLAYEDO	i	3373	`	01	<u> </u>	☐ Yes ☐ No
		Tr-Laphor		0.5	/ \	Ш	`	☐ Yes ☐ No
		By comer	\	1024	٦	Was Hy	`	☐ Yes ☐ No
		7- Micode	<u> </u>	enz	Plo	<u>1300</u>	4	☐ Yes ☐ No
		J. Micod		0 2~1	SL	DD		☐ Yes ☐ No
								☐ Yes ☐ No
								☐ Yes ☐ No
							• /	☐ Yes ☐ No
	l i	<i>;</i> ,		* • • • • • • • • • • • • • • • • • • •			• ''	□ Voc □ No

Additional De	tails (if any):								
		-								
Patient Condi	tion:	Stable	Sick-need urgent care Oth	 lers:						
	Sigń		Name Reg. No. Date							
Transferring Doctor	O.g.,		Di-vu	95466	12/1	/ry	Time 4m.			
Receiving Doctor	16	·m	Dr. Anusoya.	134559	131	1/24	1613			
Part C (to be	filled î	y Nurses)	· <i>U</i>	_			_			
Check for			Transferring Nurse			Receivi	ng Nur			
Drains		Chest A	bdominal Others:			Yes	No			
Respiratory		Air Way Type: Oxygen Therapy		rs: Rate:li/m	nin	Yes	□ No			
NG Tube / Oral		Yes No	For Feeding Gastric Suction	Fluid Restriction		Yes	No			
Foley's Cathete	 r	Yes No			_	Yes	No			
Intravenous Acc	ess	Peripheral Lir	ne Central Venous Line Others	s:		Yes	No			
Pressure Injury		Yes No	If Yes, give details:			Yes	No			
Score	_	Fall Risk: 50	WELLS: NEWS / PEWS:			Yes	No			
Patient Belongir	ngs	Yes Mo	If Yes, give details:			Yes	No			
Handover Detail	ls		inistration Record explained: Yes Reports handed over Yes \(\) N			Yes	No			
Patient Attendar	nt	Yes No	If No, give details:			Yes				
Additional De	tails (i	if any):								
	Sign		Name	Emp. No.	Date	.	Time			
Transferring Nurse		Ditio.		0241	✝ .) 	16:30			
Receiving Nurse	7	Revis	& Puerralatira	061	Vs.	alen	16,232			







FAMILY COUNSELLING FORM

CONSU	LTANT- DK	. Olnano	DIAGNOSIS-			
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
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13 તિએમ	Doctor.	forestion.	frmh upduked	1	Briling	H_ 3585,
	5 5 6 7 7					







Every heart beat counts

VIP SCALE (VISUAL INFUSION PHLEBITIS)

PATIENT NAME:

Mr.KANNAN GOVINDHAN

44/Malc/MHI202481768

AGE / SEX:

12/01/2024/IPH2024000099

Dr.G. GNANAVELU

IP No. / UHID No

Ward / Bed No. حر سه (2)

BE MONITORED IN EVERY SHIFT

<u> </u>		r=			1 '		
DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S / N EMP No.
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11/1/29							
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	ಕ್ಷೀರಾ	cubita!	210	patent	Jelusia	followed	ASHD .
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Mr.		_		-			
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Where heart best never stops...

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

Name of Patient ::

Ama / Cau

Age / Sex

Consultant Name:

REQUISITION FOR MEDICINE

IP No.

DOA

UHID No. :

Room No.:

Consu	itant Name	Room No. :	
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	<u> </u>	K.I.	

Nurse Name

Pharm Bill & Name









Where heart beat never stops...

REQUISITION FOR MEDICINE

IP No.

Name of Patient :

DOA

_ je / Sex

UHID No. :

Consultant Name: Room No.:

S.No.	Date	Medicine Name	Qty.
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Medway Hospitals

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





IP No.

DOA



Where heart best never stops...

REQUISITION FOR MEDICINE

Name of Patient :

Age / Sex : UHID No. :

pnsultant Name: Room No.:

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44/Male/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU







Every heart beat counts

15.40

15 HS

		MEDICATIO	N AD	MIN	ISTF	RATIC	N REC	ORD			
Drug	Chart	:(of	1 .	<u>-</u>	Heigl	nt (cms):	160cm	Weigh	t (kg):_ <i>ხვ</i>	<u>.56</u>	
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Drug De	etails		Descri	otion of A	Allergy	Doct	Doctor's Sign:				
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2. Write ii 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 rmat when writing time	2. Nurse 3. For ne follow 4. Stand Q8hrly	in-charge w prescrip standard ard Timing : 06:00hrs,	should ve otion, follow timings gs: Q24hrly 14:00hrs, 2	w the timing : 10:00hrs, 0 22:00hrs or 0	d omissions art on daily basis s of doctor's preso 112hrly: 10:00hrs, 2: 19:00hrs, 14:00hrs, 10	2:00hrs or 0 21:00hrs, Q	06:00hrs, 18:001 6hrly: 05:00hrs,	hrs,	
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Clinical Pharmacist

Clipical Pharmacist

Clinical Pharmacist

Clinical Pharmacist Medway Heart Institute

Clinical Pharmacist Medway Heart Institute

	ANTIMICROBIAL	. S 1	Date →	To be filled by Nursing Staff only, Sign and time given							
	To be filled in by Doctor		Time ↓	17/1/	13/1/2	14/01					
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	Nurse Signature:			70	IÀMA	11/2	D]	}	i	ſ

To be filled by Nursing Staff only. Sign and time given Date → **ANTIMICROBIALS** To be filled in by Doctors only Time 1 **DRUG NAME** T. NICODUCE 8:00 Dose Route Frequency Dr. Sign & Reg. No. / Seal Start Date & Time Stop Date & Time 9322 20:00 Additional Info: DRUG NAME Currone Clinical Pharmacist Medway Heart Instituted Route Frequency Dose 0-6m1 5.30 Start Date & Time 5:30 Q 5.30 Dr. Sign & Reg. No. / Seal 5:30 Stop Date & Time 17:30 Additional Info: **DRUG NAME** 7. PER, WORM 8,00 Dose Frequency Start Date & Time

| D | D | O | D | D |

Stop Date & Time Dr. Sign & Reg. No. / Seal 24.30 20,00 Additional Info: **DRUG NAME** 1-NIAORAN
Route 8,00 Clinical Pharmacist Addway Heart Institute Dose Frequency 1-2 Start Date & Time
12 1 210 910
Stop Date & Time Dr. Sign & Reg. No. / Sea M85851. 0010B 13/1/2401450 Additional Info: **DRUG NAME** T-PAR A-00 Frequency Dose Route Start Date & Time 9 ck0
Stop Date & Time Dr. Sign & Reg. No. / Seal 19.30 19.00 Additional Info: Area In-charge **Nurse Signature:**

To be filled by Nursing Staff only. Sign and time given Date → 'AS REQUIRED PRESCRIPTIONS Time ↓ **DRUG NAME** T. VALBAMA Frequency Dose Start Date & Time
12 1 24 09 40 20100
Stop Date & Time Dr. Sign & Reg. No. / Seal M35851. Additional Info: **DRUG NAME** INJ. PARA Frequency Route Dose 505. Dr. Sign & Reg. No. / Seal A.00 Derson Stop Date & Time Additional Info: **DRUG NAME** SYRUR SUCNOFATE Route Frequency 80 1-27 Start Date & Time Dr. Sign & Reg. No. / Seal 14/1/23 Stop Date & Time Additional Info: **DRUG NAME** Route Frequency Dose Start Date & Time Dr. Sign & Reg. No. / Seal Stop Date & Time Additional Info: **DRUG NAME** Dose Route Dr. Sign & Reg. No. / Seal Start Date & Time Stop Date & Time Additional Info: Area in-charge **Nurse Signature:**

		P	ARENTI	RAL I	SION P	RESCRIPTION AND ADIL	STR	ATION I	RECO	RD CIF		٠, س _ن	ty on
Date	Time	Intravenous	Volume	Rate /	ļ	Additive Drug				ctor		ninistratio	
- Jake		Fluid		Duration	Route	Name	Dose	Range	Sign.	Reg. No.	Start Time	End Time	
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DIET ORDERS (to be prescribed by Doctors only)											
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NURSE IDENTIFICATION RECORD

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

Date	Shift	Name of Nurse	Emp. No.	Initials	Date	Shift	Name of Nurse	Emp. No.	Initials
	Morning					Morning			
	Evening					Evening			
whip	Night	A-AJONY Le.	0/41	7		Night			
2/1	Morning	d Nandfini	Olga	4		Morning		_	
12/1/2	Evening	Maithing.	ORGO	() () () () () ()		Evening	A STATE OF THE STATE OF	,	1
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3/124	Evening	2 Pue ma latha	0211	8		Evening		1	
13/01/24		F-cathrine	0807	E.C		Night		Jaro	1
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-46-7	Evening					Evening			
	Night					Night		t.1	1 17 41

MHI/PHARM/2022/028



Mr.KANNAN GOVINDHAN

44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU





Every heart beat courses

MEDICATION ADMINISTRATION RECORD

Stat / Once Only / Premedication Drugs

Date	Time	Drug	Dana	Route		Doctor	Administered				
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ANS - CADPOVD ISHIN







Mr.KANNAN GOVINDHAN

44/Male/MHI202481768

12/01/2024/IPH2024000099

Dr.G. GNANAVELU

MEDIATE CARE FLOWCHART

UHID NO : 202481768 AGE: 444

SEX: M

SURGICAL PROCEDURE: PICA to LAD & LCX

POSTOP DAY: DI

» NAME:

FLUID REQUIREMENT:

DATE	UR	NE	Cł	IEST C	RAIN	AGE	TOTAL		I.V. FI	LUIDS		ORAI	./ R.T.	TOTAL	TOTAL
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MHI/ICU/2022/064

Every heart beat counts

Mr.KANNAN GOVINDHAN

44/Malc/MHI202481768 12/01/2024/IPH2024000099 RMEDIATE CARE FLOWCHART

NAME:

Dr.G. GNANAVELU

UHID NO:

AGE: HHY

SEX: M

SURGICAL PROCEDURE: PTCA +OLCX + LAD

POSTOP DAY: ()

FLUID REQUIREMENT:

DATE	UR	INE	CH	IEST C	RAIN	AGE	TOTAL			rŭips		ORAL	/ R.T.	TOTAL	TOTAL
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ANS- CAD / DVD /SHOW







Mr.KANNAN GOVINDHAN

44/Male/MHI202481768

12/01/2024/IPH2024000099

NAME:

Dr.G. GNANAVELU

188 MAR TRANSPORTE BARRANTAN DI KANTAN BARRANTAN BARRANTAN BARRANTAN BARRANTAN BARRANTAN BARRANTAN BARRANTAN B

MEDIATE CARE FLOWCHART

UHID NO: 2024817 AGE: 444

SEX: H

BLOOD GROUP:

HEIGHT: 160

WEIGHT: 65.5 kg

B.S.A: 1.6 m

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0.00	112	Sinus	91.6	143 96	112	mræ	44	24	Bolu	91.1	e,		
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15:00	48	grun, O	98'F	l .	105	Man	tot	21	Brlc1.	97-1	Ħ		
1 <i>5:0</i> 0	વા_	Sing	189		101.	mon	++	20	extel	984	11		
11720	Ab	Suns	98°F	150/04	113	ww	++	19	Brlci	1001	ħ		
1500	qo	Ziving	98°F	100		man	44	ಹಿ	Byld	971.	f j		
1618	989	ging	985	100	103	Monu	44	21	Byld	dô4.	tι		
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									* **				
					-								

PREVIOUS DAY - HOURS

DRAINAGE = -

TOTAL INTAKE 2 1658 M

URINE 2 1350ml

TOTAL OUTPUT 7 1350M

z - +308 BALANCE







44/Malc/MHI202481768 12/01/2024/IPH2024000099

Dr.G. GNANAVELU THE REPORT OF THE PROPERTY OF UHID NO:

SEX:

202481468

IMEDIATE CARE FLOWCHART

BLOOD GROUP:

MAME:

HEIGHT: 160 CM

B.S.A: 1.6m2 WEIGHT: 65.5R g,

		НА	EMOD	YNAM	ics			RESI	P. PARAMET	TERS	INVESTIGATIONS /
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA
[6:00	& 1	2'nu	98-b	1263	१५	Harm	\ ++	20	Epel	9 4>	- Pt On Room air
17:00	80	Sirs	958	108	88	ulisa	#	الح	88/c	961.	44
18:00.	& 1	SMS	ajsF	103	& Ω	wen	++	82	Brld	971	"
19:00	&o	Swr	98.F	126	97	ww	11	8 3	Bolal	96.1.	"
20.00	82	siny	94.3	强	93	Warm	47	22	Brd	96%	11 -
21.00	82	s; m	97.2	123		174 Per	13-7	20	Bad	96%	
22.00		s;ni	a1-2	123	91	ogra	1 **	21	13910	94,	1(
2300	જુય	3,4	at "	27	89	252	1	.20	Brd	98%	<u> </u>
00:00	83	وساي	9 % F	114	9 2			22	Brid	271.	11
0 500	80	دسى	58 F.		101	where	d'r	23	Bref	sed.	
62.000	82	Suz	98:2F	1250	95	سبهما	J+	24	1816	761)·
03%0	83	ومواج	98°F	123	୩୪	تستجعلنا	तर	20	Bolel	36.9	,,
04:00	70	Sus	S.K.P	119	13	WAY	} 2	22	Bolcl	971.	<i>''</i>
صا کا	II.	gus	98.35	137	95	wa~	дà	22	Bolel	971-	1 ₁ : '
06,00	72\	34	36+8	11/1	90	3	<i>}</i>	23	Bolel	96-)	,
13,0	42	5m	9834	127	96	hke~'	rt_	الر	Brid	77.1.	11
								PI	REVIOUS DAY	/ - HOUR	as /

DRAINAGE

URINE

TOTAL INTAKE

BALANCE