

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	1	
- 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		





Pat Mrs.UMA P Na 56/Female/MHI202381495



The way to bet			Con		very heart beat counts
(A Unit of United Alliance H		ADMI	SSION SL	IP	_
Admitting Doctor:	1. Polnan	ardu-	Speciality:	Carl	\$ (Bgis).
Advised Date & Time:	10/1/2100	D 10.3	,5am		0
Provisional Diagnosis:				1 .	
	calefi	c Cost) SRCA	de	an.
Reason for Admission:	Medical Man	agement	Surgical Ma	nagement	
	Others (pleas	se specify details	s)		<u>.</u>
Admission Type:	Day Care	ER	Ward		
	☐ ICU		_ (Specify details)		
Surgery / Procedure Nam	ne (if planned):			·	
3 ,.	,	Det		'al.	
		<u> </u>	<u>'' </u>		
Blood Product Requireme	ent: 🖳 No 🔲 Y	fes (Kindly specif	y details of componer	nts required in sp	ace below)
·	_				
Expected Duration of Sta	y:	3 clay	8	1	
Expected Cost of Treatme	ent (as per Financial			 	
Payer: Self Insurar		V	7,000		wed.
rayer. 🔲 Jen 🔛 msuran	ice [_] Others:			-90D	100 CERT
Instructions to Nurse (if a	 ny):				
)	->	hodo	(HB)	/ RB	S, S. chia
		110	`\		$\sigma h \Omega$.
010	01	billia	g done	_ //	(P)
	701 —		1		\
\sim		,	J		
Any other Instructions (if	any):				-
			$\sqrt{\gamma}$		`
		7 1	()O		
	7	, ora			, P1
Doctor's Signature	Name	- from	Reg. No.		Date \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\

			·	<u> </u>
For admission desk staff of	only:			
. 🗆	General Ward Single Room Twin Sharing Deluxe Room Suite Room Others			
Admission intimation	Receipt Details	Admission Time	in HIS	
Date	Time	Date	Time	_
16/1/24.	(0.34an)	10/1/24	10:4	0
To be filled only if Blood	OPD ER Direct requirement specified by the	e Doctor: pleted as advised:		
Front office Staff Signature	Name	Emp. No.	Date	Time
Think?	Proith ba	0192	10/1/24	10:40

.



Medway Hospitals

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)



Mrs.UMA P

56/Female/MHI202381495 10/01/2024/IPH2024000083

Dr.G. GNANAVELU





MHI/HOSP/2022/129

ADMISSION FORM

,	ADMISSION FORM	
Marital Statu	Full Address NO 56/93 DR Radhakrishnan Nog.	Telephone Number
M	Thiruvottrijuv	9840572276
Occupation	Chenna - 19	
Referred from		tal No. of Days
Dr. Ci	.C. 10/1/24 10/10/10/10/10/10/10/10/10/10/10/10/10/1	leigs
Dr. Cu UNIT	MLC Yes No If Yes AR No.:	
,	FINAL DIAGNOSIS	ICD Code
·	CAD - SICHNIFICANT CALCIFIC LAD & RCD	T25.1
	SB (36.12.23) BIFASCKULAR Block.	
<u>190</u>	RMAL LY FUNCTION TYPE II DIABETE	T50.1
MELL	etus typothyrordum,	E11.9
	DYS HIDIDBMA	E03.9
	·	E-18.5
DATE	OPERATION / PROCEDURES	ICPM Code
	SUCEBSFOR IUWS GUIDED pront	
· Int	STENT TO LAD USING RESOLUTE ONLYX 2-76x 26 mm & PCCA 78TENT TO RCA USING	00.66
10/1/01	2.76x 26 mm & PCCA 78TBALT TO RCA USING	
]	BY HERLY 2. 50 X 6 MM DONE ON 10.1,24	
DATE	TYPE OF ANESTHESIA	
colilor	☐ GENERAL ☐ SPINAL ☐ REGIONAL	☐ EPIDURAL
	DISCHARGE STATUS	
☐ Cured	☐ Discharge at Request	Expired < 48 hours
t Improve	☐ Against Medical Advice	Expired > 48 hours
☐ Unchang	☐ Absconded	Post-Operative Death
CDY. G	IGNAMIVELUCI)	-
1 75	an Modfast	THR.

AUTHORISATION FOR TREATMENT I PAYMENT

administer such drugs as may be ne	cessary and to perform su e in the diagnosis and trea	d Paramedical, Staf f of the Hospital Investigate treat and choperation under anaesthesia or other wise as may be tment of my illness / patient
I hereby under take to settle all the b basis. In any case, I shall pay all the		ges related to me/the patient named overleaf on a periodic arged from the hospital.
		s agreed above, I hereby authorise the hospital to transfer ent as deemed fit and proper by the hospital authorities.
- -	nt or theis attendants have	and Regulations of the Hospital and that all cash, jewellery been removed to a place of safety / handed over to the regard to any loss.
I have read out and explained the co	ntents of the above to the	Signatory in his vernacular .
சிகீச்சை, பணம் செலுத்துதல் முதலியன	வ செய்ய அதிகாரம் வழங்கு	தல்
மருந்துகள் கொடுத்து செய்முறைகள்/அ செலவுக்கன தொகை முழுவதும் செலுத் மேல் கூறியது போல் வேளை நான் தா	க்கு தேவைப்ப றுவை சிகீச்சை செய்யவும் ப த இதன் மூலம் உறுதி அளிக் க்கள் மருத்துவத்திற்கான செ	: வைுகளை கட்டத் தவறினால் என்னை நோயாளியை வேறொரு
மருத்துவமனைக்கு, பிற சிச்சை / அறு அளிக்கிறேன்.	வை சிகீச்சை செய்ய இடமாற்	ற ஒப்புதலை எனது உறவினா்கள் மூலமாக பெற நான் அதிகாரம்
மருத்துவமனையின் பொது சட்ட திட்டங்	கள் பற்றி தெரிவிக்கிப்பட்டிருக	க்கீறேன்.
•	·	5ட்கள் யாவும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்லு என எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை
மேற்குறிப்பிட்ட அனைத்தும் எனக்கு வி	வரிக்கப்பட்ட பிறகுதான் கை6	் பயாப்படிட்டேன்.
Odn		
ടെങ്ങിலിயர் തങ്കവെന്ന് വന്	தேதி	எனது/உறவினர்/காப்பாளர் கையொப்பம்
Signature of Admitting Nurse	Date	Signature of the Patient / Relative / Gurdian
	10/1/24	Alar.

Nature of Relationship

englown Hasterel



discharge.





Mrs.UMA P 56/Female/MHI202381495 10/01/2024/IPH2024000083 Dr.G. GNANAVELU



GENERAL CONSENT FOR ADMISSION

i,	the Patient or Representative of patient have
"	lease tick the correct option above and below) Read
	☐ Been explained this consent form in English, which I fully understand.
•	I give my full consent and authorization for admission and treatment at this hospital. The proposed treatment plan has been explained to me.
•	I consent_and authorize the hospital, treating doctors, nursing, technical and paramedical staff to provide relevant care and to conduct diagnostic as deemed necessary by the treating doctor/team.
•	I also consent to 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.

	<u> </u>			
_	Signature / Thumb Impression*	Name	Date	Time
Patient	P. Vlus	P. Uma	10.1.24	10.40
Surrogate/Guardian (if applicable #)	No	ア・A Ru w (いなとらて) (Write name and relationship with patient)	10/.129	10 48
Reason for surrogate consent	Patient is unable to give consent l	because:	_	_
Witness	Dre.	PARUNACHALAM	10/1/23	10:40
Interpreter (if applicable)				

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







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DISCHARGE SUMMARY

IP No.

IPH2024000083

UHID

MHI202381495

Name

Mrs. UMA. P

Age / Gender

56Years / FEMALE

Consultant

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

Chief Cardiologist

D.O.P

: 10/01/2024 : 10/01/2024

Room No. : 112

D.O.D

D.O.A

: 12/01/2024

DIAGNOSIS:

CAD – SIGNIFICANT CALCIFIC LAD & RCA DISEASE (26.12.2023)

BIFASCICULAR BLOCK

NORMAL LV FUNCTION

TYPE II DIABETES MELLITUS

HYPOTHYROIDISM

DYSLIPIDEMIA

PROCEDURE:

SUCCESSFUL IVUS GUIDED PTCA + STENT TO LAD USING RESOLUTE ONYX 2.75 X 26 MM & PTCA + STENT TO RCA USING SYNERGY 2.50 X 16 MM DONE ON 10.01.2024.

BRIEF HISTORY:

Mrs. Uma. P, 56 years old Female, Presented with complaints of chest pain & shortness of breath (NYHA class-II) .She underwent Coronary angiogram on 26.12.2024 which revealed CAD - SIGNIFICANT CALCIFIC LAD & RCA DISEASE. Hence she was advised for IVUS GUIDED PCI to LAD & RCA for which she has been admitted.

No H/O fever, cough, pedal edema, vomiting, diarrhea.

Known case of Type II diabetes mellitus, hypothyroidism and dyslipidemia.

N/K/C/O systemic hypertension, CVA.

ALLERGY: SULPHA

ON EXAMINATION:

Patient Conscious, Oriented and afebrile.

PICCLE

NIL

HR

92bpm

BP

130/90mmHg

SPO₂

99% in room air

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Medway Centre of Excellence (Chennai)

Kodambakkam

Mogappair

Chengalpattu

Villupuram

Kumbakonam

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

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

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



UHID: MHI202381495



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CVS - S1S2 (+)
RS - BAE (+)
Abdomen - Soft, NT

INVESTIGATIONS:

CNS

BLOOD(10.12.23): Hb- 12.0gm/dl, Creatinine – 0.47mg/dl, Na+- 138mmol/l, K+- 3.51mmol/l,

ECG: Sinus rhythm, HR - 78 bpm, PVC(+)

NFND

ECHO: Normal valves & chambers. No wall motion abnormality. Normal LV function. EF - 75%. Normal pulmonary artery pressures. Occasional ventricular ectopic.

POST PROCEDURE INVESTIGATIONS:

BLOOD(11.12.23): Urea – 13 mg/dl, Creatinine – 0.51mg/dl.

ECG: Sinus rhythm, HR - 82 bpm, PVC(+)

ECHO: S/P PTCA. Chambers normal sized. No RWMA. Normal LV systolic function. EF – 62%. Grade I diastolic function. Normal RV systolic function. All valves are normal. IAS /IVS intact. Trivial TR. No PAH. No pericardial / pleural effusion. No clot / vegetation.

COURSE IN THE HOSPITAL:

Mrs. Uma. P, 56 years old Female, admitted with above mentioned complaints. Basic investigation was done. After obtaining consent, She underwent SUCCESSFUL IVUS GUIDED PTCA + STENT TO LAD USING RESOLUTE ONYX 2.75 X 26 MM & PTCA + STENT TO RCA USING SYNERGY 2.50 X 16 MM DONE ON 10.01.2024 by Right femoral approach. Post procedure period was uneventful and shifted to CCU. Post procedure ECG shown no fresh ischemic changes. She was treated with DAPT, statin and other supportive measures. Her general condition improved & Right femoral site normal, no hematoma/ bleeding. She got shifted to ward, RFT within normal limits, maintained adequate fluid balance. Her medications are optimized and she is being discharged in a stable clinical condition.

CONDITION ON DISCHARGE:

Patient Conscious / Oriented / Afebrile

General condition Stable

GCS - 15/15

Temp - 98.6°F BP - 130/70mmHg
PR - 80/min SPO2 - 97% in room air

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Villupuram

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Chengalpattu

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UHID: MHI202381495



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ADVICE MEDICATIONS:

SI.	NAME OF THE DRUGS WITH	DOSAGE	FRE	QUENC	Υ	ROUTE	RELATION	DURATION
NO	GENERIC NAME		M	A	N	7	SHIP WITH MEAL	
1.	TAB. ECOSPRIN	75MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2.	TAB. AXCER	90 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
3.	TAB. CREVAST	40 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4.	TAB. CORDARONE	200 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
5.	TAB. CALBRIT	1 TAB	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
6.	TAB. EVION LC	1 TAB	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
7.	TAB. FOURTS B	1 TAB	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
8.	TAB. THYROX	75 MCG	1	0	0	ORAL	EMPTY STOMACH	TO CONTINUE
9.	TAB. REMMAG	400 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
10	TAB. PANTOCID	40 MG	1	0	I	ORAL	BEFORE FOOD	TO CONTINUE
11	SYP. CREMAFFIN	15 ML	0	. 0	1	ORAL	AFTER FOOD	TO CONTINUE

+ DIABETES MEDICATIONS:

	NAME OF THE DRUGS WITH	DOSAGE	FREQU	JENCY		ROUTE	RELATION	DURATION
NO	GENERIC NAME		M	A	N		SHIP WITH MEAL	
1.	TAB. TRIVOLIB	1 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. STALIX	50 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE

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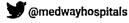
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Institute of Pulmonology 044-2473 4451

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UHID: MHI202381495



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DISCHARGE ADVICE					
DIET	LOW FAT & DIABETIC DIET.				
PHYSICAL ACTIVITY	AS TOLERATED.				
REVIEW	REVIEW WITH DR.GNANAVELU AFTER 1WEEK WITH RFT,ECG REPORTS.				

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

CONSULTANT SIGNATURE

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

Typed by: Ezhilarasi.

"I understood the Content of the discharge summary."

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

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Mrs.UMA P

56/Female/MH1202381495 10/01/2024/IPH2024000083

Dr.G. GNANAVELU





INPATIENT INITIAL ASSESSMENT

Date: loll 24 Time of arrival in ward: 12-10.
Allergies (if Yes, specify details): Drugs Pes No Sulfa Allugy
Blood Transfusion
Food Yes No
Others
Vital Signs: Temp 11 (°F) Pulse / HR: 12 (beats/min) BP: 180 90 (mmHg) Respiration: 22 (breaths/min) SpO ₂ : 9 (%) Height: 166 (cms) Weight: 460 (kgs) BMI: 326 (f) W
Pain: Yes No. If Yes, Score: 9/0 Pain Scale Used: Numerical Rating Scale (>12 years) CPOT (ventilator / comatose) Duration: Location:
Pain Character: Dull Aching Sharp Stabbing Shooting Burning Referred / Radiant Pain
CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS So yrs old female blood TeDm Came with Complaints of Shortness of Breath less run (NYHA - class-12) K I days: - No Ho Palyttation - No Ho Fever, vorming love that - no Ho Fever, vorming love that - no Ho Palyttation - no Ho Pever, vorming love that Palent Game for pica of LAD & RCA PAST MEDICAL HISTORY (with duration of illness): Diabetes Mellitus: Pies \(\text{No. If Yes, duration:} \) Hypertension: \(\text{Yes} \) Hypertension: \(\text{Yes} \) No. If Yes, duration: \(\text{Yes} \)
Others: Nikles Bronchial Asslma / KOPP / Pulmonary 78/ chD/epilepsy,
Past Surgical History: N.L.

Present Medication (for Medication Reconciliation):								
S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during , hospital stay		
1.	7-Trivolib	Ing	Pb	6-1	2000 alile	n. ✓Yes ☐ No		
٦.	T. Founds B	ltab	Pla	100	1000000 4	∑Yes □ No -		
3.	T. Statix	Som	P/0	101	_6000 n	∕∐Yes □ No		
4.	T- Cal brit.	Itab	Pb	Loo	200 20.m	Yes □ No		
S.	T- Thyrox	75thcg	Pb	Las	1000 Y	✓ Yes □ No		
Ь.	T. Ranozex	کصمع	Ph	Los	ahl24	☑Yes □ No		
7.	T. Evion Lc	ltab	Pb	0-01.	n `.	Yes □ No		
8.	7- Pantocid	4000	96	Lai	alilzy.	√Yes □ No		
9.	T- Ecosprin	Fory	P/ ₀	0+0.	alily.	∠ Yes □ No		
10.	T. AKCEN	gang	Pb.	has	9/1/24	Yes □ No		
Farr	illy History: T. Crevark	yay	Pho	0-0-	aliley	060 /NO		
'"	NZL	, 0		•				
	•••							
						,		
		\		y				
	rsonal / Social History (Tick which							
	estyle: □ Sedentáry Æ Active noking: □ Yes ☑No Alcohol	: ☐ Yes [alion: <u>· </u>	Recreationa	I Drug Use: ☐ Yes ☐	No I		
Ot	hers:			<u>.</u>	:			
Mer	nstrual and Obstetric History (to b	e filled uj	o for fema	le patients):				
	_ \}	- *		P2 AT	· ·			
	Patio	at at	tained	ljnem	have byes	before		
]	The state of the s							
Ge	eneral Physical Examination							
	_		es ⊠No_	_	Clubbing: Yes	□₩o		
Ed	ema: ☐ Yes ☐ No Lyn	nphaden	opathy: [JYes □ No	· · · · · · · · · · · · · · · · · · ·			
	• •					;		
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SYSTEMIC EXAMINATION	
cvš:	
$S_1 S_2 \mathcal{D}$, no numerous.	
Respiratory System:	
Respiratory System: BACP, No added Sounds.	
Gastrointestinal System:	
Soft, NT, no organome soly	
Central Nervous System: No facal neuro official deficit	
Urinary / Reproductive / Locomotor System:	
(v)	
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	MO
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 'Verification: Yes: If the answer is "YES" to any 2 questions, the patient is at Normal and not at risk	•
Provisional Diagnosis: 72DM) Calcific LAD & RCA disease Dystipudeni	\overline{J}
Hypothytodiom)	
Plan of Care: - Plan! PTCA + IVUS. (Iday.) LADS RCA NPO from 10 Pm.	
- Mander entals - No flow dry clears	
- Consent.	

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Investigations Advised:							
	To do	Hb, RBS		. 1,		-	
To do Hb, RBS, Sr. Ereadinne							
	A. ·		•		·:		
Diet Advice:			_	,			
☐ Nil per Oral	Clear liquid diet	Normal liquid	d diet	Diabetic I	iquid diet		
Semisolid diet	Soft solid diet	South Indian	normal diet	☐ North Ind	lian normal d	iet	
☐ Neutropenic liquid	diet	lou da	مار رفاق	s fat			
Early Discharge Plan	ning (fill in those which are	appropriate at thi	s stage):	PFE: Pa	tient Family E	ducation	
Special support need	ed at home	☐ Yes ☐ No	o If Yes, PFE done				
Home equipment ant	cipated	□Yes☑Ño	If Yes, PFI	E done and equ	ipment advis	 ied	
Physiotherapy at hom	ne anticipated	☐ Yes ☐ No	If Yes, educated on physical limitations, if any				
Wound care needs ar	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 needs	3	☐ Yes ☐ No	If Yes, educated on dietary restrictions, food drug interactions and allergies				
Continuous / ongoing	care anticipated	☐ Yes ☐ No	. If Yes, educated on various aspects of ongoing care required				
Other special educati	on need, i.e.:	☐ Yes 🗹 No	If Yes, PFE done				
Nature of post hospital infection control, fall r	al needs like patient safety, isk, etc, addressed	☐ Yes ☑No	If Yes, spe	ecific education	given		
Others:			,				
	Signature	Name		Reg. No.	Date	Time	
Resident Doctor	1000	Dr. Marie	dly dross	•	10/1/24	12.0	
Consultant [or. G GRANAVELU	tr. and	inately	:29467	गागिय	50 % G	
Patient Attendant	18	Relationship	ر محسر	· •	10/11/201	11-20	

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CONSENT FORM FOR CRITICAL CARE (ICU)

I, MTS. OM9 above and below):	_ the Patient or Representative of patient have (please tick the correct option
☐ Read ☐ I have been explained in detail by the trepatient's illness and I am aware of the all the ☐ Been explained this consent form in Engleprovided about ICU Treatment	reating doctor and I understand about the condition of me / and my patient or my possible outcomes. ish/, which I fully understand and understood the information
needed to improve the patient's condition. I hereb	uss with the doctor about the condition of myself or my patient, treatment options, procedures by give consent to treat the illness of myself or my patient and to do emergency procedures like is of securing airway, mechanical ventilation, central venous access, arterial lines and further ove 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.

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- · Difficulty in getting peripheral venous access.
- When high dose vasopressors are needed, ischemia to the distal part of the limb.

Alternative Forms of Treatment: Peripheral Venous Access

ENDOTRACHEAL INTUBATION

Brief description of the Procedure:

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

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

Intended benefits:

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

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

Possible risks and complications:

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

Possible alternatives:

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

I am now aware of the intended benefits, possible risks and complications, and available alternatives to the said procedure. I am also aware that results of any procedure can vary from patient to patient; and I declare that no guarantees have been made to me regarding success of this procedure. I am aware that while majority of patients have an uneventful 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				1
Surrogate/Guardian (if applicable #)	ATY.	A ISH WARY A (Daughter) (Write name and relationship with patient)	10-1-24	9:10
Reason for surrogate consent	Patient is unable to give consent because:			
Witness			_	
Interpreter (if applicable)				

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

l, 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.

in in a co	escribed in this decument.				
	Signature	Name	Reg. No.	Date	Time
Doctor		Dr. h. Atislu	Q ja 10	10/1/27	- 14
				$\overline{}$	



(A Unit of United Alliance Healthcare Pvt Ltd)

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



உயிர்காப்பு சிகிச்சைக்கான (அவசர சிகிச்சைப் பிரிவு / ஐசியு) ஒப்புதல் படிவம்

		என்ற	பெயர் கொ	ாண்∟ பநோ	ாயாளியா	ன அல்	லது 🛭	் நோயாளியின்	பிரதிநிதி	யான	
	நான்,	இந்த	ஒத்திசைவு	படிவத்தை	(மேலே	மற்றும்	ьсер	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

🗆 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 பேரிய 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. ஆன்ட்டிபயாட்டிக் மருந்துகள் மற்றும் கீமோதெரபி 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.
- புறவெளி லைன் வழியாக வாசோபிரெசர்ஸ் ஐ வழங்குவது சீறிய இரத்த நாளங்களுக்கு சேதத்தை விளைவிக்கும் என்பதால், அதிர்ச்சியில் ஆழ்ந்துள்ள ஒரு நோயாளிக்கு வாசோபிரெசர்ஸ்களை (இரத்த அழுத்தத்தை அதிகரிப்பதற்கான மருந்துகள்) வழங்குவதற்கு.
- சில நேர்வுகளில், டயலாலிசிஸ் செய்வதற்கு மைய லைன் மீது இரண்டு குழல்களைப் பயன்படுத்தலாம். இரத்தநாள அமைப்பிலிருந்து இரத்தத்தை எடுப்பதற்கு ஒரு குழலையும், டயலாசிஸ் செய்யப்பட்ட இரத்தத்தை உடலுக்கு திரும்ப அனுப்புவதற்கு மற்றொரு குழலையும் பயன்படுத்தலாம்.

சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள்:

- போருத்தப்படும்போது 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 ஆக்கிவிடும். கதீட்டர் பொருத்தப்படும் இடத்தை தூய்மைப்படுத்துவது மற்றும் பேண்டேஜ் செய்வதில் சிறப்பு கவனம் செலுத்தப்படுவது தொற்றுக்கான இடர்வாய்ப்பைக் குறைக்கக்கூடும்.
- இரத்தஉ நைவு
- ஒழுங்கற்ற இதயத்துடிப்பு
- நுரையீரல் 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 இரத்தஓட்டத்தடை

சிகிச்சையின் மாற்று வழிமுறை வடிவங்கள்: புறவெளி சிரை / நாளத்திற்கு அணுகுவசதி

முச்சுப் பெருங்குழலுள் குழாய் செருகுதல்

மருத்துவ செயல்முறையின் சுருக்கமான விவரணை:

முச்கப் பெருங்குழலுள் குழாய் செருகுகல் (Endotracheal Intubation) என்பது, தாங்களே சுயமாக கவாசிக்க இயலாத அல்லது நினைவிழந்துவிட்ட நபர்களுக்கு செய்யப்படும் ஒரு அவசரநிலை சிகிச்சை செயல்முறையாகும். இது, ஒரு திறந்தநிலை மூச்சுப்பாதையை பராமரிக்க வகை செய்கிறது மற்றும் மூச்சுக்தினுறல் நிகழாமல் தடுக்கிறது. நீங்கள் கவாசிப்பதற்கு உதல, உங்களது /உங்களது நோயாளியின் மூச்சுக்குழலுக்குள் ஒரு நெகிழ்வுத்திறன் கொண்ட பிளாஸ்டிக் குழாய் வாய் வழியாகப் பொருத்தப்படுகிறது. மூச்சுக்குழலு அடிச்சிறது. மூச்சுக்குழலு ஒரு குழாயாகும். கவாசிப்பதற்கான இந்த குழாயின் அளவு நேரயாளியின் மழ்ச்சுக்குழலு ஆக்சினனை நுறையீரல்களுக்கு எடுத்துச்செல்லும் ஒரு குழாயாகும். கவாசிப்பதற்கான இந்த குழாயின் அளவு நேரயாளியின் வயது மற்றும் தொண்டை அளவிற்குப் பொருத்தமானதாக தேற்கு செய்யப்படும். உட்செலுத்தப்பட்டதற்குப் பிறகு குழாவைய சுற்றே விறிவடைகின்ற காற்றின் ஒரு சிறிய சுற்றுப்பட்டையின் மூலம் உட்செலுத்தப்பட்ட குழாய் அதே இடத்தில் இருக்குமாறு வைக்கப்படும். முச்சுக்குழாய், குரல்வலைக்கு சற்றுக்கும் தொடங்குகிறது மற்றும் மாற்பு எலும்பிற்கு பின்னே வரை அது நீள்கிறது. அதன்பிறகு முச்சுக்குறும் இரு கிறு குழல்களாக பிரிகிறது: வலது மற்றும் இடலு மற்றும் மற்றும் மாற்பு எலும்பிற்கு மின்ன வரை அது நீள்கிறது. அதன்பிறகு முச்சுக்குறும், அகன்பிறகு முற்றுக்குள் சிறு சிறு காற்றுப் பாதைகளாக தொடர்ந்து பிறிகின்றன. முச்சுக்குறாய் என்பது, கடினமான குருத்தலுவரு திகைவரை திகைகளால் ஆன்றது. ஒல்வொரு முச்சுக்குறாய் என்பது அதன் முற்றைய கற்றிவருக்குமனான திகைக்களால் அல்லது கவாசிப்பதில் சிறம் இந்தகையை தருணத்தில் தான் முச்சுப் பெருங்குழலுள் குறாய் செருகுதல் அவசியமாக இருக்கக்கூடும். இத்தகைய திருல்குகுல் தான் முச்சுப் செருக்கும் கையியமாகையை அடைப்பின்றி திறகம் இருக்கலாம். இத்தகைய தருக்கும் தான் முச்சுப் பெருங்குழலுள் குறாய் செருக்கும் சியம் குருக்கலாம். இத்தகைய தருக்கும் தான் முச்சுப் பெருங்கும்றன் கவக்கிறது. நீங்கள் சுவரியமாகையை அடைப்பிற்றி சிறம் இருக்கலாம். இத்தகைய தருக்கும் தவையில் வைக்கிறது. நீங்கள் சுவரியமாக அருக்கக்கும். இத்தகையின் தவையில் கையியமாக அருக்கக்கும். இத்தகையில் தவையில் கையியம் சிக்கக்கும். இத்தகையில் தவியியின் தம்பிக்க கும்கள் கையின் தன் கிறது மற்றும் குற்றும் மற்றும் மற்றும் குறதும் சிக்குறும் காண்டிக்கு

அடையத் திட்டமிடப்பட்டுள்ள பலன்கள்:

தாராளமாக சென்று வருவதை இது அனுமதிக்கிறது.

கழ்வரும் ஏதாவதொரு காரணத்திற்காக இந்த மருத்துவ செயல்முறை உங்களுக்கு /உங்களது நோயாளிக்குத் தேவைப்படக்கூடும்:

- உணர்விழ்ப்பு மருந்து, பிற மருந்துகள் அல்லது ஆக்சிஜன் போன்றவந்றைப் 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 இருக்குமானால்):

சாத்தியமுள்ள மாந்று வழிமுறைகள்:

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

மேற்குறீப்பீடப்பட்ட மருத்துவ செயல்முறையீன் மூலம் அடைய தீட்டமிடப்பட்டுள்ள பலன்கள், சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள், இந்த செயல்முறைக்கு கிடைக்கக்கூடிய பீற 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. செமும்பான்மையான நோயாளிகளுக்கு அசம்பாவிதம் இல்லாமல் அறுவைசிகிச்சை மற்றும் மீண்டு குணமடைதல் நிகழ்கின்ற நேற்வில், சில நேர்வுகளில் சிக்கல்கள் திக்கல்கள் கூடும் என்பதையும் நான் அறிந்திருக்கிறேன். மேலே குறிப்பிடப்பட்டுள்ள இந்த மருத்துவ செயல்முறைபோடு தொடர்புடைய பொதுவான இடர்கள் மற்றும் சிக்கல்களை நான் அறிந்திருக்கிறேன். எந்தவொரு மருத்துவ செயல்முறையிலும் ஏற்பட சாத்தியமுள்ள ஆயத்துகள் மற்றும் சிக்கல்கள் அனைத்தையும் பட்டியலிட சாத்தியமில்லை என்பதையும் நான் புரிந்துகொள்கிறேன்.

இந்த மருத்துவ செயல்முறையின் தன்மை மற்றும் சாத்தியமுள்ள இடர்கள் மற்றும் சிக்கல்கள் மற்றும் உத்தேசிக்கப்படும் நன்மைகள் மற்றும் சாத்தியமுள்ள மாற்றுமுறைகள் பற்றி நான் அல்லது மேலே பேயர் குறிப்பீடப்பட்டுள்ள எனது நோயாளி முமுமையாக அறிந்திருக்கும் நிலையில் எனக்கு விளக்கப்பட்ட மேற்கண்ட மருத்துவ செயல்முறைக்கு சுயவிருப்புத்துடன் எனது ஒப்புதலை நான் அளிக்கிறேன்.

மேலே பெயர் குறிப்பிடப்பட்டுள்ள நோயாளியான /நோயாளியின் பிரதிநிதியான நான், இப்படிவத்தில் கைபொப்பமிடும் தேதியில் 18 ஆண்டுகள் வயதுக்கு மேற்பட்ட, சீரான நல்ல மனநலம் கொண்ட நபராக இருக்கிறேன் மற்றும் எந்தவித அச்சம், அச்சுறுத்தல் அல்லது தவறான கண்ணோட்டம் இல்லாமல் இச்செயல்முறைக்கு

	கையோப்பம் / கட்டைவிரல் ரேகை*	டெயர்	தேதி	நேரம்
நோயாளி				
பதிலாள் / பாதுகாவலர்			-	
(பொருந்துமானால் #)		(பெயர் & நோயாளிக்கு என்ன உறவுமுறை]	
		என்பதை எழுதவும்)		
	நோயாளியால் ஒப்புதல் வழங்க இயலவில்னை			
பதிலாள் ஒப்புதல்	1.	• •		
வழங்குவதற்கு காரணம்				
சாட்சி				1
மெழிபெயர்ப்பாளர்				İ
(பொருந்துமானால்)				

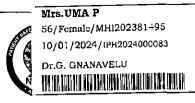
^{*}ஆண்களுக்கு வலது பெருவிரல் மற்றும் பெண்களுக்கு இடது பெருவிரல் ரேகை பதிவு | # உரிய வயது வராதவராக அல்லது ஒப்புதல் கொடுக்க இயலாதவராக நோயாளி இருந்தால் மட்டுமே.

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

	கையோயம்	பெயர்	பதிவு எண்.	தேதி	நேரம்
மருத்து வர்					









Every heart beat counts

DOCTOR'S PROGRESS NOTES

	DOCTOR 3 PROGRESS NOTES
DATE	NOTES
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	Pot 378m at 24 alm 101.
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-	360 Calcification (circumprential)
	plagne hwilm 7-7%
-	PKD-2.75 mm
	port MSA - 6.12 mm²
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DATE	NOTES
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Mrs.UMA P

56/Female/MH1202381+95 10/01/2024/IPH2024000083

Dr.G. GNANAVELU





Every heart beat counts

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





Mrs.UMA P

56/Female/MHl202381495 10/01/2024/IPH2024000083

Dr.G. GNANAVELU





Date	10	t	94
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ICU PROGRESS NOTES

Time: 20.00

Doctor's Name: DR. VELMOURUELAN

(as Appropriate)

ICU SCORES

CLIF ACLF / AD score:

SOFA score:

MELD score:

AARC score:

SAPS II score:

APACHE II score:

ICU Day - | Background

cro con

Issues last 24 hours

puto un

Central pervous system

Conscious / oriented / sedated with

Sedation score

GCS - E V M F

Pupils -d mm th

Drains

Cardiovascular system

HR - HE M Rhythm - M L Cardiac Output -

BP - 140 / 20 CYP-Cardiac Medications

Respiratory system

Oxygen supplementation - ~4

Saturation / PaO2-

Ventilator: Spontaneous Controlled

Last C x R -Drains - GIT

P/A & /}-

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. and

1. 04

2.

Foley's Yes / No

ET Tube / Tracheostomy tube - Y / N.Day

Culture reports

Antimicrobials with days

1.

2.

3.

Labs

Hp \Q\L_LC

Platelets

DVT prophylaxis = X/1N Drugs:

Mechanical - TEDS / SCD

Urea

Creatinine

Na

Κ

Bilirubin

11

AST

ALT

Drugs

Pressure sore Y / N

Stress Ulcer Prophylaxis - Y/N

Alpha bed Y / N

INR

Others

	<u> </u>			,	r 1 ;
Plan for	r the day				
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Doctor	Signature	Name Bry-VCL	Reg. No.	Date	Time
<i>!</i>	V /	Br-V-C	10-10-0	10/1 /cg	102





Mrs.UMA P

56/Female/MHI202381+95 10/01/2024/IPH2024000083

Dr.G. GNANAVELU





Every heart beat counts

	DOCTOR'S PROGRESS NOTES
DATE	NOTES
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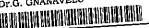




Mrs.UMA P

56/Female/MH1202381495 10/01/2024/IPH2024000083

Dr.G. GNANAVELU





Date: (1) 1/2024

Time: 5mm

ICU PROGRESS NOTES

Doctor's Name: DR AWIJA

(A Unit of United Alliance Healthcare Pvt Ltd)

ICU SCORES

CLIF ACLF / AD score:

(as Appropriate)

SOFA score:

MELD score:

AARC score:

SAPS II score:

APACHE II score:

ICU Day 2

Background

CAO

and out throng wiasy

Issues last 24 hours

70 CAO TRCA

Central nervous system

Conscious / oriented / sedated with

Sedation score

GCS-EVM Pain score ** `` **Pupils**

Drains

Cardiovascular system

HR - 7 -Rhythm -

Cardiac Output -

BP-110/20 CVP -Cardiac Medications:

Respiratory system

Oxygen supplementation - 气マス

Saturation / PaO2-

Ventilator: Spontaneous / Controlled

Last C x R -Drains -

GIT Silv P/A

Bowels - Y/N Loose stools / Melena

Drains 1

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

2.

Mechanical - TEDS / SCD

Foley's Yes / Nø

ET Tube / Tracheostomy tube - Y / N Day

Culture reports

Antimicrobials with days

DVT prophylaxis - Y/N

1.

2.

3.

Labs

Hb (レ

TC

Platelets

Creatinine 0:47 - 0,5)

Urea 🔗 Na 138

K 3.51

AST Bilirubin

ALT

Stress Ulcer Prophylaxis – Y/N

Drugs

Drugs:

Pressure sore Y / N

Alpha bed Y / N

INR

Others

Plan for the day							
- In -	MJBIU 28		÷.,		-		
	- SHAT DO LIAMO GOST WHAD						
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]	Sigņature	Name	Reg. No.	Date	Time		
Doctor	Luly	Dirwigs	P8477	וונואטא	-		







56/Female/MH1202381+95 10/01/2024/IPH2024000083

Dr.G. GNANAVELU

Medway Heart Istitute

MHI/IP/2022/041

beat counts

DOCTOR'S PROGRESS N	

DATE	NOTES
11/24	8/B. De. Dujith. B. (DMO).
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DATE	NOTES					
11 1 24	3/B Dr. Anusuya					
	SP PICH TO LAD.					
23.00	patient reviewo					
25 00	clo' mild pain in the procedure site					
_	0/8: Patient Conscious, Wilentell,					
-	3/E' CNS - 6152P)					
	RS - BASE					
vitals stable	LE RO Radial proexime Adulco					
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	- continue daugs as pers					
	chart					
	- W/F hematama desatametern					
	HOURTSPIKES.					
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j





2381+95 24000083

MHI/IP/2022/041

Heart
Institute

Every heart beat counts

Dr.G. GNANAVELU

	DOCTUR 3 PROGRESS NOTES
DATE	NOTES
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PRE/POST OPERATIVE ECHO

Mrs.UMA P 56/Female/MHI2023 10/01/2024/19H202 Dr.G. GNANAVELU	4000083
	Screening Echo
Date & Time	S/P PTCA
11.01.2024	
8:20 am	- No pericardial I pleural effusion
	- Chambers normal sixed
	- NO RUMA
	Normal LV Systchie function
	. Grade I diastolie function Normal RV Systolie function
	Normal RV Systolic function
	- Ay values are normal
	· IAS / Ivs intact
	· Trivial MR
	· Trivial TR. NO PAH
	· No clot regetation of
· · ·	· Ectopics during study, HR! 77 bpm
	LUIDD! LEZMIN EMP. D'ES
	- tri
	LV105: 28 MM Med E/E: 9.91 EF: 621. Lat E/E: 6.0
	EF: 621. Lat =1E. 6.0 TRP9: 15 mm Hg
	simpson's EF Rusp: 25 months
	311195871 C1 [W3P]
	EDV: biml RV TDI: 12 cm/s
	ESV: 2 tml TAPSE: 16 mm
	EF: 551.
	Done by: Tibiah (PA, Res)
	MH1/0052/AD.





Every heart beat counts

Mrs.UMA P

56/Fernalc/MHI202381495 10/01/2024/IPH2024000083

Dr.G. GNANAVELU

URINE ROUTINE ANALY	rsis MICROBIOLO	<u>GY SHEET</u>	
DATE	28/12/23		
COLOUR	PALE YELLOW		
REACTION	5-5		
SPECIFIC GRAVITY	1.007		
APPEARANCE	CLEAR		
ALBUMIN	Wagatie		
SUGAR	Norma		
ACETONE			
BILE SALT			
BILE PIGMENT		_	
UROBILINOGEN	Not Inclared		
PUS CELLS	0.6		
EPITHELIAL CELLS	1-5		
RBC	0-2		
CASTS	Nel		
CRYSTALS	_ N.)_		
OTHERS	Ni		

MICROBIOLOGY-CULTURE REPORTS

DATE	SPECIMEN/SITE	GROWTH- 24h, 48h, ORGANISM	SENSITIVITY
1			
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DIABETIC CHART



Every heart beat counts

Mrs.UMA P

56/Female/MHl202381+95 10/01/2024/iPH2024000083

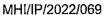
Dr.G. GNANAVELU



ACTUAL WEIGHT FR. Lg. HDA,C T. Trivalib Ing to 1. (A4) PREVIOUS DIABETIC MEDICATIONS T. Starlin Somy to 1. (A4) DATE TIME BLOOD SUGAR DIABETIC DRUG Sign. ENDORSED BY 10/124 11:20 122 mg/dl. T. Trivalib Ing of TR. Akrl Ad. 11/124 6. A5 196 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Ad. 12.00 233 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Ad. 12.10 233 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Ad. 12.11 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Ad. 12.12 D. Sanglal T. Trivalib Ing T. Starlin Comp. Dr. Akrl Ad. 12.13 D. 154 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.13 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.13 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.13 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.13 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.13 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.13 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.13 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.13 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.13 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.13 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.13 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.13 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.13 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.13 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.13 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.13 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.14 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.15 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.15 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.15 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp. Dr. Akrl Bullon 12.15 D. 181 mg/dl T. Trivalib Ing T. Starlin Comp.

INSTRUCTIONS FOR INSULIN INFUSIONS

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









Mrs.UMA P

56/Female/MHl202381+95 10/01/2024/tPH2024000083

Dr.G. GNANAVELU

BLOOD GROUP

B positive

INVESTIGATION SHEET

_		 		_	, 	T
Date	28/m/hs	10/1/24	11/1/224			
<u>HAEMATOLOGY</u>	1	,	, , ,			
Hb		12.0			ļ <u>.</u>	
P.C.V		<u> </u>				
Platelets					, , ,	
TLC						<u> </u>
Polymorphs				_		
Lymphocytes	-			_		
Eosinophils						
Mono / Basophils						
E.S.R						
BIO-CHEMISTRY	23/12/23					
Urea	ı		\3 .	. •	ļ	
Creatinine	-0.56	0.42	0.51.		•	
Sodium		138				
Potassium		3.51	-	•		
Bicarbonate	_	18				
Chloride		18	·			
Magnesium						
Calcium				-		
Phosphorus						
LFT						
T.Bilirubin						
D.Bilirubin						
I.Bilirubin						
S.G.O.T					T	
S.G.P.T						
ALP						
GGT						
Total Protien						
S.Albumin						
CARDIAC ENZYMES				· ·		
Troponin 1		<u> </u>				<u> </u>
CKNAC - CPK						
CK - M.B. MASS						
LDH						
Ntpro bnp		†	-	<u> </u>		
					- 	

RBS

249

Date	23/2/23						1
COAGULATION		1				_	1 -
PT / INR						-	
Fibrinogen	-						1.
D Dimer			-			-	1
LIPID PROFILE							1
Total Cholesterol						 	1
Triglyceride		 					1
H.D.L		<u> </u>			-	-	1
L.D.L	 	 					ſ
VLDV		 				-	1
THYROID FUNCTION							1
T.S.H				• • •	•		
T.3		<u> </u>	<u> </u>	-			1
T.4		 					┨
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FBS/PPBS	7 110			<u>-</u>	<u>. </u>		ł
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C.R.P			<u> </u>		-		-
PROCALCITONIN	 	_					ł
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S.Osmolality							
URINE	-						
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ALLERGY sulph a





MIS.UMA P

56/Female/MHI202381495

10/01/2024/IPH2024000083 dr.g. gnanavelu

VITAL INFORMATION SHEET

BLOOD GROUP ON ADMISSION Height in CM Weight in Kg. 166 11

Diagnosis:	4	/ /() •	<u>}</u>	<u>)(</u>	/1	2		Dg	<u>1</u> 9	_	16	11) <i>6</i>	\sim	IA) -						F	Pro	се	du	re	: 1	P	† (A.	+	<u>,</u>	5 6	Ą	+	-1	-A	D	•	?	<u> </u>	٧ı	Ų.	<u>s</u>			-	<u> </u>	<u> </u>	0 _	_			_	_	 				_	_
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Every heart beat counts

RING CHART

EARLY WARNI Name: Patient Id No: Age/ NEWS key DATE DATE 12/11 12 1 2 3 TIME TIME >25 >25 Respirations 21-24 2 21-24 Breath/ min 18-20 18-20 15-17 15-17 12-14 12-14 9-11 9-11 <8 <8 9 A+B >96 >96 SPo2 Scale 1 94-95 94-95 Oxygen Saturation (%) 92-93 92-93 <91 ,] <91 Spo2 scale 2 oxygen >96 on oxygen >96 on oxygen saturation (%) use scale 2 If target range is 88-92 % in hypercapnic Iratory fallure only 95-96 on o2 95-96 on o2 escale 2 under the 93-94 on O2 93-94 on O2 tion of qualified >93 on air >93 on air ian 88-92 88-92 86-87 1 86-87 84-85 84-85 Air.or Oxygen ? A≃ Air • A= Air O2litre/ mln O2litre/mln Device >220 3 Blood Pressure 201-219 201-219 181-200 181-200 161-180 161-180 141-160 121-140 121-140 111-120 111-120 91-100 91-100 81-90 81-90 71-80 71-80 61-70 61-70 51-60 51-60 <50 <50 क्षिक हिए हर् के किर्वेश stolle BP mmHg mmHg >131_ 121-130 >131 121-130 2 111-120 111-120 101-110 101-110 91-100 91-100 81-90 81-90 71-80 71-80 61-70 61-70 51-50 51-60 41-50 41-50 31-40 31-40 <30 <30 Alert Alert 71 Consciousness Confusion Confusion Score for New onset of ٧ confusion (no score if chronic) U >39.1 degree Celsius E >39.1 degree 2 Celsius 38.1-39.0 Temperature 38.1-39.0 Dagree Celsius 37.1-38.0 37.1-38.0 35.1-37,0 36.1-37.0 35.1-36.0 35.1-36.0 < 35.0 _< 35.0 **NEWS Total** ā Note: Nurses are trained to Call edge 39 (10) when they get score of 3 in any single parameter or aggregate score of > 5 Monitoring Frequency Escalation of Care Y/N Initials by RN initials by Sr. RN

Score and

monitoring

frequency

4

3

2

Every Hourly

Every 2nd Hourly

Every 4th Hourly



Mrs.UMA P 56/Fcmalc/MHI202381495 10/01/2024/IPH2024000083 Dr.G. GNANAVELU





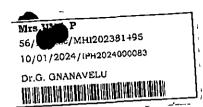


TO AN IRAN FOR EACH DOOR FOR THE CONTRACT OF T Every heart beat counts Bed No: From: /o Date I **INTAKE & OUTPUT** Ended Time: 7400. 24 Hrs: Started Time: 11-2 **CHART** NPO Started at : NPO Over at: SHIFT Restricted Fluid (RF) Morning **Afternoon Night** door INTAKE **OUTPUT** The m Difference: Total Intake: **Total Output:** INTAKE (ml) **OUTPUT (ml)** Intravenous Infusion Tube N/G Drain Total .. **Endorsed** Time | Oral **Vomitus** Others R/N Sign Feeding Type of Fluid Urine Time Aspirate Tube **Additions** by Amount 300 200 11.30 200 1140 300 TO FOV entalse Cath Lab. 350m 150ml casth











Date		om: [₁		0: 19 1 94	, Be	d No:						INITA	VE 0	OUT	DUT
24 Hr	s : St	arted Time	- 00:4:	_	Ended T	ime :´Ţ',	00					INTA			ןיטי
		ed at :			NP	O Over a							CHA	'K1	
SHIFT Morning Afternoon					Nigh	t		Restricted Fluid (RF)							
INTAI	KE	·	58@h		1050	-	20	esmi							
OUTF	TU		280		400			236	doml						
Total I	ntake				otal Outpu	ıt:				Differen		_			
		T	INTAKE	<u> </u>						OUT	PUT	<u>(ml)</u>			
Time	Oral	Tube Feeding	Intrave	nous Infusions		- E. 1	Time	Urine	Vomitus	N/G Aspirate	Drain Tube	Others	াত্র	R/N Sign	Endorsed by
		(Total	intako	= 2000	ml									
			Total	output	<u> </u>	ļ 	ůn	CCO	. <u>(a)</u>					ļ	
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Mrs.UMA P 56/Female/MHI202381+95 10/01/2024/IPH202400083

Dr.G. GNANAVELU







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Date		<u> </u>	To To): 3 12		d No:	111					INTA	VE 9	OUT	DUIT
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NPO	Starte	d at:				O Over a							CHA	KKI	
SHIF	Τ	N	lorning		Aftern	ioon			Nigh	t		Rest	ricted F	luid (R	F)
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_			INTAKE	<u></u>						<u> </u>	PUT	(ml)			
Time	Oral	Tube		ous Infusio		Tickell 1	Time	Urine	Vomitus	N/G	Drain	Others	572.CST	R/N Sign	Endorsed
		Feeding	Type of Fluid	Additions	Amount	िस्त्री	Inne	OTTITE	Volintus	Aspirate	Tube	Others	I ICIEIN	Roll Olgii	by
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Every heart beat counts

Mrs.UMA P

56/Female/MHI202381+95 10/01/2024/IPH2024000083

Dr.G. GNANAVELU



Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

- 66 · · · ·		Weight:Kgs	,	(2/0.		حا	
ous Beliefs:		Vegetariany	☐ Non Vege	etarian		Eggetarian	Jain
rescription:	Mooo	calacia, b	2 104 1- 0	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		n light of	·+-
JECTIVE	GLOBA	AL ASSESSMENT	(ADULTS)	2 Varr),, (A)(<u> </u>	·
			(1.15)				
	(A) -	Patient's related Medical Hist	ory				
	11	Weight Change (overall chang	· · · · · · · · · · · · · · · · · · ·	<u> </u>		•	
	1-1	Testing to the land	D2			<u></u>	105
	_	No weight change/	<5%	5 - 10%		10 - 15%	>15%
·		gain				<u> </u>	
2)	Dietary Intake	Duration:			i	· ·	
_		<u> </u>	□ 2	□ 3			□ 5
	Oral -	No change	Sub - optimal / solid diet	Full liquid die moderate overall decre		Hypo-caloric liquid diet **	Starvation
	Enteral /	Adequate /	Sub - optimal	Inadequate		Typo - caloric	Stanvation
	Parenteral Nutrition	Excessive				feeds	
3)	GastroIntestin	sal Symptonia Duration:			.		
		10.	□2	□ 3		□ 4	 5
		No symptoms	Nausea	Vomiting/		Diarrhoea	severe anorexia
		1 1 1 - 1	,	moderate GI symptoms	•	, .	S 1 1 1
<u></u> د کا ک	Functional C	apacity (Mutrition related functional imp	nairment) (Turadon)	зуприля	.		
	1	10 i	2	3			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
· `		None /Improved	Difficulty with	Difficult		. Light activity	Bed / chair -
,			ambulation	normal	activity	,	ridden with no or little activity
5)	Co - morbidity	Disease and its relationship to nutrition	n requirements)				
	1	□ 1 .	□ 2	-		Q4	<u> </u>
		Realthy	Mild co -		erate co -	severe co -	Very severe
			morbidity		bloity/age years	morbidity	morbidity
8)	Physical exam	nination		·]			1 1 1
1)		stores or loss of subcutaneous fat	· · · · · · · · · · · · · · · · · · ·		-		
<u></u>		- T			7		
	 	Normal	. Mild	Moderate			Severe
2)	Sign of muscle v		,	1 %			
·			□ 2				<u> </u>
	1	Normal	Mild	Moderate		- · · 	. Severe
Total Score = S	ium f above 7 com	ponents	1 1				
			<u> </u>			4 4	
Nutritional Sta	tus : Based on this	patient is			· · · · · · · · · · · · · · · · · · ·		
-	Well Nourished			12 10 14)	; ,;		
	Moderately Ma	inourished		[15 to 18]			
	Severely Maino	urished		☐ (19 to 35)		1)	
		1f_		•		T	
Nutrition Inter	vendon:						
	Oral			☐ Enteral		Parenteral	
	g provided;	D Yes		□ No			
Diet counseillr							
Frequency of a	e-assessment:	Weekly			☐ Fort - night	☐ Monthly	

Maria Catherine John (201)

Senior Dietitian

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
whiley,	A toyean old finale court do chut pain wer arrived to be well	
. · ·	rouished an enident by SUB. Kleb- Drif Diplips demia / Hypothys	dina.
	Patrint shifted to Costlean fi provid (peux) and nept or HOM. Patrent inin	
·	dealster which dit can initiate on	Oalaw
18/1/24,	deaththe, soft which diet. Patrick wind Broard. Reempfied a	0.10
14100	fee dit entration. notoated beat	Maria Catherine John Senior Dietitian
lafyru, com	Deal intake is good. Educated the patriet and family or 1500 calorin, a feet, on sout, dealson. dist on disches	
	Empfor man fut man. Can ge control. Dit was cotton and clayso due. Dit chat give on derelage	Senior Dietitian
-		

Application of the



Patient P.

Mrs. UMA P

56/Female/MHI202381+95

10/01/2024/IPH2024000083

Dr.G. GNANAVELU



PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: CAD-DUD Allergies if any: TW- Subhud Wild.									
<u> </u>	T	To (Area		Date	Time		<u> </u>	ame of Procedure	
From (Are				٠,,	┝┈	+		aille di Procedure	
15t Floor. Cath low to 12 Hard PTCA Method of Transfer: On Bed On Wheelchair On Stretcher									
Method of Tra	ınsfer: 🗌	On Bed 🗆 Ør	Wheelc	hair 🗌 On S	Stretche	er 			
ASSESSMEN General cond	T OF PAT	TIENT: Patient: Con	scious 🗆	Semi-cons	scious	☐ Un-conso	cious		
Language Ba	rrier: 🔼	Yes ☐ No ☐ If	Yes, spe	cify:		<u></u>			
Fall Risk Cate	gory: 🗌	Low Risk D Me	dium Ris	k 🗌 High R	lisk				
Vital Signs (to	be docum	nented at the tim	e of shift	ing):					
Temp (°F)	RR (b	reaths/min)	Puls	e (beats/mir	1)	SpO ₂ (%)	BP (mmHg)	Pain Score	
1.20	21	4	C	12		99	180/20	-	
☐ Numerical F Any pre-medic Any critical inf	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:								
Handover by	Signa	iture	Nan	- /1 }	Mar.		Emp. No.	Date Time	
Handed over to)	lo		Daveth	යන් 🗸	1	0176	(0) 184121-10	
Procedure com	After Procedure: Procedure completed: Yes Yes Any critical information: Vital Signs (to be documented at the time of shifting):								
Temp (°F)	RR (b	reaths/min)	Pulse	(beats/min	1)	SpO ₂ (%)	BP (mmHg)	Pain Score	
94.5	98-F 22 mm H 84 b+ ml 100-1. 10/73 mm H 0/60								
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)									
	Signa	iture	Nam	ne			Emp. No.	Date Time	
Handover by			(1)6	vetha	ggi		0176	10/1/24/7-00	
Handed over to	,	Mint.	T OF or	Thans!	MAN ALI		MSH	100 100 1700	



Heart Institute

Every heart beat counts

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

Mrs.UMA P

56/Female/MH1202381495

Patient Name

10/01/2024/IPH2024000083

Consultant:

Dr.G. GNANAVELU

GIOGRAM / CORONARY ANGIOPLASTY

Sex: M/F

UHID

CONDITION AND PROCEDURE

Dr. CARNAVELU has explained that I have the following condition:

Fat (cholesterol) and calcium can build up in the arteries like rust in old pipes. It can stop the flow of blood to the heart. This can cause angina or a heart attack. The Coronary Angiography procedure is performed to show up the amount of disease in the coronary arteries, the blood vessels that supply the heart with 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	Plug	P. Oma	10/1/24	11-20
witness	1800	P. AR un AchorA		11.20.
Doctor	5 Kory 60	Prhia	10/1/24	11-20-
Interpreter				



MHI/CRD/2022/026	
Medway	
(' Heart \	
Institute	

கிருதய ஆன்ஜியோகிராம் பரிசோதனைக்கான ஒப்பம்

Evenu	heart	beat	counts

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

நிலை மற்றும் செயல்முறை

பழைய இரும்புக் குழாய்களில் துருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாரடைப்பிணை ஏற்படுத்துகிறது. இதயத்திற்கு நத்தத்தினை வழங்கும் நத்தக்குழாயான இதயச்சுவர் சிரை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியரேகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு கேறுக்கல் அனைத்தப்படிக் 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 மதிப்படவும் மற்றும் அது எவ்வாறு பம்ப் செய்கிறது என்பதை மதிப்படவும் 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 உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகிட்சையை மேற்கொள்ள முடியும். இவை பை-பாள் அறுவை சிகிட்சையாகவும் இருக்கலாம். சிலைது ஆன்ஜியோயிளான்டி (புதூன் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

இச்சையல்முறையிலுள்ள கிடர்பாடுகள்

இதயச்சுவர் சிரை ஆன்ஜியோகீராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிரை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள சில தீவிர இடர்பாடுகள் பின்வருமாறு. அனால் கிவைகள் மட்டுமே முழுமையான இடர்பாடுகள் அல்ல

10,00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிக்தம்)	(a) கதீர்வீச்சின் 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 மீடியத்தின் (டை) ஆப்த்தான 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 ஆன்ஐயோயிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதீர் பாதீப்பு காரணமாக அதீக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	 (1) இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகீச்சை தேவைப்படு. (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
வெரும்பாலான மக்களுக்கு	(11) சிறிய அளவிலான சிராய்ப்பு

நோயாளி ஒப்புதல்

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

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







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

TRANSFEMORAL PERCUTANEOUS CORONARY INTERVENTION + IVUS STUDY REPORT

Patient name

MRS. UMA.P

ID:

MHI202381495

Age/Gender

56 F

IPH:

IPH202400083

Cath No.

3584/3585

D.O.P.

10.01.2024

Done by DR. GNANAVELU

Technician : Mr. Ram

Scrub nurse: Ms. Sathya

DIAGNOSIS: CAD, BIFASCICULAR BLOCK, NORMAL LV FUNCTION,

TYPE II DM, HYPOTHYROIDISM, DYSLIPIDEMIA.

CAG: SIGNIFICANT CALCIFIC LAD & RCA DISEASE

PLAN: IVUS GUIDED PTCA X LAD & RCA

APPROACH : Right femoral artery

Total exposure time: 3133"

HARDWARE: 6F sheath, 6F EBU 3.0 / 6F JR 3.5 guide catheter

Total RAK: 467.10 mGy

CONTRAST : CONTRAPAQUE 200 ml

Total DAP: 229.33 Gy.cm2

MEDICATIONS: Inj NTG 200 mcg IA; Inj. Heparin 7500 IU;

HEMODYNAMIC DATA: ABP 153/71 (105); HR 90 bpm; SPO2 99%

ARTERY	LESION	GUIDE WIRE	PRE DILATATION	STENT	POST DILATATION	RESULT
LAD	70-80% TUBULAR STENOSIS	BMW J	2.0 X 10mm Apolio NC & 2.5 X 20mm Across HP 18 atms	2.75 X 26 RESOLUTE ONYX 12 atms 20 s	3 X 8mm POT 14 atms	TIMI III FLOW
RCA	70% TUBULAR STENOSIS	BMW J Tip	2.0 X 10mm Apollo NC 12 atms	2.5 X 16 SYNERGY 11 atms 15 s	2.5 X 10mm Across HP 18 atms	TIMI III FLOW

REMARKS: IVUS study with Opticross 60MHZ catheter was used to optimize and assess stent deployment pre & post dilatation. LAD - Pre MLA - 2.2 mm² with 77% plaque burden(Calcific). IVUS parameters of LAD stent were satisfactory. MSA of LAD stent was 6.17 mm². ACT at the end of the procedure was 275 sec.

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

Chief Cardiologist Reg. No: 39469

Dr. G. GNANAVELU, MD, DM

Medway Centre of Excellence (Chennai)

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

Villupuram

@MedwayHospitals

Mogappair

Kodambakkam

(i) @medwayhospitals

Chengalpattu

medway-hospitals

Kumbakonam

@medwayhospitals

Kakinada

94557 94557 1800 572 3003

Medway Group of Hospitals

Heart Institute 044 - 4310 8959

Institute of Pulmonology 044-2473 4451

044-2473 4455 | 044-26530011 | 044-27426829 | 04146-242000 | 044-2473 4455 | 0884-2333337 E-mail: info@medwayhospitals.com | Website: www.medwayhospitals.com | CIN: U74900TN2011PTC083665

MHI/HOSP/2022/118

Mrs.UMA P 56/Fernalc/MH1202381+95 10/01/2024/IPH2024000083

	anavelu III II II III III III III III III III			MHI/NUR/2022/046
	20 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	NURSES PROGRESS NO	TES	
Date & Time		Observations / Action	· 	Signature with Emp. No.
10/184		eath cab:		* -
14.10	- PE REC	gived from Ist fla	por to	
		conecious and onep		
,;	1	stable IV line		·
,	į.	Patent. VID Scon		1017
14.30		30m1/h7 QV P-		·
, .		lapping done. PTG		
		cedure started.		(N) -0
12.70	1 .	femoral arteral	OUDDrawl	28176
		al anaestholig.	- 1 / XXXX	
14.40		Sparin 5000 IA. 9	isven	
191:040		Dr. GIGI(188).		lu ,
1H. Flo	· ·	entary) 25 MCg+IH	`Cmalat	20.130
		en ola Dr. Ott		
14-45		o (100) mm H3 HP: 88		20
101 12		Vitali stable.		(1)
14.50	J. Thi: alkar		given	COMPO
101750	OB DA.	GOI CETED	Jiva)	
15,30	=) BP: 1H	8/74 CHMM(20) 4/8	2; 80 b+ lm+	100
10.30	b)Pod:99-1.	1 . 6	- 10 DA 11101	1.00
18,50	JACT.		00-1	0140
151,50	O/R Dr.	-294 secs the	CREAL	
lk ho	0/12 - 170 ·	Glyceir) teparin 1500 I	1/ 01 Non :	NP)
<u> </u>	O /R DY	tepanin 1500 g	v gruen	Warth .
16.00			9 _	- 01914
16.20			Po bt/mt	
16.20	b 200%			
16.30	· '	275 see cheeko	_	(//
16.25	3	due TVUS + PTU	· · · · · · · · · · · · · · · · · · ·	1 1000
	and Rea	, ,	noral	+
-	Arterial Signature	Shoath Theore Kept	L ÚN Emp. No	Date Time
Document	. (2)	Catticia		
endorsed by	X	15919	000	011/24/633

	NURSES PROGRESS NOTES	
Date & Time	Observations / Action	Signature with Emp. No.
10/1/24	Position. Plastel bandage applied	
16.38	no oosing & home tome	
17-00	=> Pt Shiffed to CW all	\sim
	reporte band was and Pt femoral.	(M) ap
	axterial sheath is mints once.	200176
	watch. The femoral site hand	
	over to PlN. Rathing Priys.	Jo He
	·	
	·	9
,	·	
,		
,		·
	·	
_	Signature Name Emp. No	
Document endorsed by	dathigs ool	6 10/1/24/17-00



Mrs.UMA P







Every heart beat counts

Procedure Monitoring Sheet (Cath Lab)

Pat	icht Name.	6/Female/MH1202381 0/01/2024/1PH202400		A	ge / Sex :		
UH	ID/IP: a	or.G. GNANAVELU		, , <u>,</u> N	/ard Unit:	•	
Cor	nsultant:			D	iagnosis:		
		Procedure Che	ecklist (Please tid	_ -		Ward Nurse)	
		PARAMET			YES	NO NO	NA NA
Vital si	ans: BP:130/0	toTemp:Ω∏P		25. SP0299		· : ·	
Urine v		<u></u>					
	preparation						
Pre-pro	ocedure medica	ation administere					
Proced	lure site marke	d		. ,			
Skin pr	eparation done						
NPO	_lo · 2	30 Am					
Loose	Tooth removed						
Contac	t lenses / Eye	glasses removed					
Prosthe	esis present						
Jewelle	ery/Nail polish ı	emoved		<u> </u>	¥.		
Checke	ed for Allergies	(Drug / food)	Sulpha Al	Geray Sop: As	thelin.	_	
IV line/	In-situ						
Conser	nt taken ————	·					
Investig	gation reports /	Documents rece	ived				<u> </u>
Signatu	re of Nurse :	Con .			Date & Time	1011 ~	4 at 11:80.
		Intra Pro	ocedural Reco	rd (To be filled by	the Cath Lab Nurs	se) ———————	_
Time	HR / min	RR / min	BP mmHg	SpO ₂ %	Medicatio	on / Remarks	Sign. of Nurse
14.30	86 B+ M		162 96 (11.	4) 99-/-			116
14,45	88 PHM+		01)08J OH	0) 99-1.		<u>-</u>	DUPOITS
15.15	80 BJ/MA	1 -	146/746	4	_		JUL O 17
16,45	82 bt/mt	-	135/82 (U				Month
16.15	76 57 lm		132/83(10			-	(IVn)
16.30	Sto by IN	1-7-X	180173(1)	00) 100-/-			YWO 16
		 	h 0 . 11 . 1 . 1	المحما	- 600		

Time : _		16,45		Route:	P4 .	femore	ul anteri	al
Complica	ation: N	<i>i</i> /					appro	ach
		mmHg, HR						
Distal Pเ	ılse:	felf.	, Puncture S	Site: <u>140</u>	000 N	- P	hema to n	\sim
Advise:								
♦ Bed♦ Obset	erve puncture ch for Pulse i	e site for bleedir in <u>Pt fer</u>		<i>,</i> .				
a) l' b) l' c) lí ♦ Rem to th	f patient com f dressing is limbs are Coove P+ + e consultant.	ical Officer SOS uplains of any Di Loose or Socke old / Absent Pul emoral on if any:	scomfort d with Blood se on a essing on <u>J1</u>	1,124 <u> </u>	at _	• •	AM /PM a	~, » 2 m lb
			POST PROC	EDURE OB	SERVATION	ON		
Date & Time	BP HR	RR SpO2%	Site Eva	aluation	Extremity	Status	Remarks	Sign. of Nurse
Ship 16-45	50/80 79	20 100%	ho post	ende.	Good	P	2	UB 013
17-00	14874 70	22 607		natome	C OO	d		a de la companya della companya della companya de la companya dell
			1	_ · 				
)				
Nurses N		cedule 2005.	t PTCA+01	AD omd	PEA	dore	. Pet ?	femoral
arte	rial	sheath	tep	t en	Posi	Him t	plas.	tel
he	nodage	cupp)	ied. r	100 OO	ينام	. I ho	mg tome	
	n at the end o	of procedure : _	Stable	ř	tical	Other		,
Name &	Signature of	the Nurse :			Date	· & Time :	1,104	O
	9	yperto				ام	``@' TT	*U -

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





SAFE PROCEDURE CHECKLIST Adapted from WHO Safe Surgery Checklist



Every heart beat counts
Mrs.UMA P

56/Female/MHI202381495

	_	١,		36/Female/MHI202381+95
Name of the Procedure :	2VVI+A179	Location:	<u>ab·</u> Date & Time :	10/01/2024/IPH2024000083
·				Dr.G. GNANAVELU
Does the Procedure involve	Procedural Sedation : 🖊	Yes ∏No		<u> </u>
SIGN IN 12 . 3D		TIME OUT 13 · YU After procedural Sedation and before		SIGN OUT 16 2 3 When Doctor indicates that the Procedure is completed
Before Induction of Procedural S		-		
(Anaesthetist / Qualified Physicia Sedation + Nurse + Technician + Do	in administering Procedural	(Anaesthetist or C	Qualified Physician administering Procedur performing the Procei	al Sedation + Nurse + Technician + Doctor
Patient Confirmation	ocioi pengiriiliig ale procedute)	All team members introduce themselves I		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	4 ^d Yes	Procedures PIGA + TVU	Yes	Name and site of all specimens / investigations ☐ Yes ☐ NA
Side	☑Ŕt □Lt □NA	side Rt fernoral a	approall DRI DLI DNA	confirms labeling and sent to lab
•		Expected Blood lossN.a.		
Consent	☐ Yes	Position supine.	₹ Yes	Any recovery concerns : ☐ Yes ☐ None
Known Allergy	Tyes No	Consent	□Ye8	If Yes, Pls. specify:
	If yes, plaese specify	Required equipment and implants availab	ole Yes NA	
Difficult airway / aspiration risk	☑No ☐ Yes, equipment	Essential Imaging displayed	∠ Yes □NA]
/ dentures	and assistance available	Antibiotic prophylaxis within last 60 minut	es ☐Yes ☐NA	
Possibility of hypothermia	☐ No ☐ Yes, warmer in place	Name of the Antibiotic given		Any Equipment / instrument problem that needs to be addressed : ☐ Yes ☐ None
i	/	Venous Thromboembolism Prophylaxis P	Provided Yes NA	addressed:
All concerned anesthesia equipment	and medication check complete	Anticipated duration briefed	□Yes]
Spo2 NIBP Other	s pls. specify <u>CC</u>	Anticipated blood loss briefed] ()
Pre OP medication taken	☐Yes ☑No	Adequate fluids and blood available	☐Yes-□NA	1 \1
Tro or moderation taken		Team briefed on any critical or unexpecte		Corrective action :
Required equipment for	□ Yes □ NA	For procedural sedation cases] / /
procedure available	(Any patient specific concerns : Intra procedure glycemic control	☐ Yes ☐ None	١
		Any concerns about sterility	Yes NA	1
				9.1 04
Anaesthetist / Doctor giving Procedural Sedation /	Doctor performing the Procedure:	Nurse: RIN . Ca	thit grant Technician: Mg. 9	Others Please Specify:
r rocedural devalion	riocedule.	(1/2)	9941	0000
Date: 10/1 Ay	Date: 10) 18	Date: Intila	y Date: 10/1/24	Date :
Time: If 100	WY Time	Time: 10 (1/0	Jime: If the	Time:
1	11116. 16. H	7. 1 16-47	10,47	· · · · · · · · · · · · · · · · · · ·

Patient Details (Affive Labor) MEI ALLERGY Sof Female/MH1202381495 10/01/2024/1PH2024000083 Dr.G. GNANAVELU







Date of Admission: Time of Arrival: Mode of Admission: Walking Wheelchair Stretch Accompanied by Relative: Yes No If Yes, Name of the Relative: Arrival: No.: Opun 5 de American Stretch Accompanied by Relative: Contact Person's Name: Relative: Arrival: Arrival: Arrival: Stretch Accompanied by Relative: Contact Person's Name: Relative: Arrival: Arrival: Indian International Interpreter needed: Yes No Patient status: Conscious Unconscious Disoriented	ier						
Accompanied by Relative: Yes No If Yes, Name of the Relative: Relationship with Patient: Contact Person's Name: Relative: Tamil English Indian International	ier -∯.						
Relationship with Patient: Contact Person's Name: \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \							
Contact No.: 000 5 40 A Primary language spoken: Tamil English Indian International	"						
Interpreter needed: Yes No Patient status: Conscious Unconscious Disoriented							
Interpreter needed: A Yes No Patient status: La Conscious La Uniconscious La Disoriented							
	_						
Menstrual History: LMP: Menopause: Patient Vulnerable: Yes Notice! HIN Co. Merbidity: Patient Vulnerable: Yes	10						
Medical History: DM / HTN / Co - Morbidity: 6 1976 If Yes, specify / Drugs History: Antiplatelet (Specify)							
Psychological Status: Calm Anxious Withdrawn Agitated Depressed Sleeping Difficulty							
Over the past 2 weeks, how often have Not at Several More than one Nearly	_						
bu been bothered by any of the following all . Days half of the days every day	al						
problems?							
1. Little Interest or pleasure in doing things 0 1 2 3							
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? Yes No							
If Yes, specify details:							
Socio Economic Status: Employed Retired Own Business Home-Maker Others:							
Vital Signs: Temp: 97 1 (°F) Pulse / HR: 90 (beats/min) BP: 150 80 (mmHg)							
Respiration: (breaths/min) SpO ₂ : 992(%) CBG: (mg/dl) Height: (cms) Weight: (kgs)							
Allergies / Adverse Reaction: Yes No Medication Blood Transfusion Food Not known							
If Yes, specify: The Rubherdnes Syp: Asthoulin.							
Pain: Yes No. 1 Yes, Score: Pain Scale Used: NRS(>12 years) CPOT (ventilator / comatos	se)						
Duration: Location:							
ain Character: Dull Aching Sharp Stabbing Shooting Burning Referred / Radiant Pain							
Nutritional Screening:							
Last 3 months Appetite: Increased Decreased No Change							
Last 3 months Weight: Increased Decreased No Change							
Type of Patient: Diabetic Non Diabetic Type of Diet: Normal cut	_						
Dietician Informed: Yes No. If Yes, mention the Name:Time:							
Orient Patient if: Conscious Orlent Patient Attendant if: Unconscious Disoriented							
Proom Side Rails Totlet Bell Patient Information Board Bathroom Ded Controls							
Use of Footstool							
Functional Assessment:							
Particular Assessment Remarks Outcome							
Visual Impairment Yes No							
Hearing Impairment Yes No							
Chewing Difficulty Yes No							
Walking Difficulty Yes No							

			.,						
Daily Activity Of L	iving:								
Activity		Independe	nt	,	Assisted		Dej	pende	nt 2
Bathing									,
Dressing									
Eating							-		
Walking							丁		
Toilet Use					$\overline{\Box}$			$\overline{\sqcap}$	
Pressure Injury R	isk Asses:	sment: Brad	en Scale		·	<u> </u>	,		
Sensory Percep		Score	Moisture		Score	Degre	ee of Activity	, [Score
No Impairment		4	Rarely Mois		4		Frequently		4
Slightly Limited		3	Occasional		3		Occasionali	v -	3
Very Limited		2	Very Moist	<u>, </u>	2	Chair		-	2
Completely Limit	ed	1	Constantly	Moist	1	Bed F	ast		1
Mobility		Score	Nutrition		Score	Fricti	on & Shear		Score
No Limitation		4 /	Excellent		4/	No ap	parent prob	lem	
Slightly Limited		3	Adequate		(3	Poter	itial Problem		2
Very Limited		2	Probably In	-Adequate	2	Probl	em Present		1
Completely imme	obile	1	Very Poor		1				j
If yes, Location:_ Witnessed by:		<u></u>				Rela			
Fall Risk Assess	sment (Mo	odified Mors	e Scale):	`					
Variables						•	_	Num	eric Value
History of falling	(immediate	e or within 6	months)				No		∠ ₀
						<u>-</u>	Yes		25
Secondary diagr	nosis (≥ 2	medical diag	Inosis)				No Yes		0
	•		·	<u> </u>			tes		
Ambulatory Aid None / Bed Rest		eeiet							9
Crutches / Cane		33:31		_					15
Furniture	<u> </u>							-	30
Intravenous Ther	ony / Hon	orin Look / Tu	iboo Ingitu				No		_0
intravenous mer	ару / пера	ann Lock / It	ines msitu				Yes		20
Gait		.							
Normal / Bed Re Weak	st / Wheel	Chair							10
lmpaired							 		20
Mental Status				_					
Oriented to own	stability								0
Overestimated or forgets limitations							•	15	
Medications									
	Includes PCA / opiates, anticonvulsants, anti-hypertensives, diuretics, hypnotics, laxatives, hypoglycemics, sedatives, immunosuppresent and psychotropics						No	_,	0
	•	·			 		Yes		<u>/15</u>
Score Interpretation	า: 0-24: Low	v-risk; 25-44: N	1edium Risk; Ab	ove 45: High	Risk	Total So	core		()

s per the score, tick the following appropriate	boxe	es:							
Familiarize the patient with the immediate surrounding Remind the patient to use call bell before getting out of Keep the two side rails in the raised position at all times Keep the call bell, bedside table, water, glasses within to Remove excess equipment or furniture to make a clear Keep the patient's bed in the low position at all times ex Teach fall-prevention techniques, such as sitting up for Bed wheels should be locked Encourage family participation in the patient's care Ensure that floor of the bathroom is dry and not slippen Review medications for potential side effects that can perfect with the low remains Lead to the patient of the patie	bed for all he pa path cept c a mod re to b cher ited for tor fects ment a restrict sees' st riate) in then	tient during ment ote fal oe am or he level areas nd sh ctions	s easy reach g procedure before rising from the be lls bulated only with assista avy or debilitated patien of consciousness, ga	ance ats in a					
Initial Assessment to Special Needs and Vulnera	bilit	y of		<u>.</u>					
	Yes	No	Remarks (ple	ease specify)					
Terminally ill patients	<u> </u>		• •						
	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		\angle							
Patients whose immune system is compromised									
Patient with infections and communicable diseases									
Does the patient have implants		, ,	-	•					
Has tracheotomy been done		1							
Has colostomy been done			/						
Any other potential needs of the patient									

DVT RISK ASSESSMENT Assign a score of 1 if (YES) in parameter nos. 1 to 9, and assign a score of -2 if (YES) in parameter no. 10 S. No. **Parameters** Yes / No Score 1 Active cancer (on-going treatment or diagnosed within 6 months or palliative care) Yes No 2 No Bedridden recently >3 days or major surgery within four weeks Yes Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle 3 No Yes (Assess for both legs) 4 No Collateral (nonvaricose) superficial veins present (Assess for both legs) Yes Entire leg swollen (Assess for both legs) 5 Yes No 6 Localized tenderness along the deep venous system (Assess for both legs) Νo Yes 7 Pitting edema, greater in the symptomatic leg (Assess for both legs) No Yes 8 Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs) Yes No 9 Previously documented DVT (Assess for both legs) Yes No Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) 10 Yes 'Νο oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture. Risk Score Interpretation (Probability of DVT): **Final Score** Tick the score obtained (\checkmark) **Action Taken** Date Time Low Risk -2 to 0 2 Moderate Risk 1 to 2 40 High Risk 3 to 8 Personal Belongings / Valuables: Name & Signature of the With With Patient's Description Valuables Remarks Patient / Patient's Attendant Attendant Patient □ Upper □ Lower **Dentures** □Both ☑Nil □Right □ Left **Hearing Aid ⊅**Nil Eye glasses / ☐ Yes / ☐ No **Contact lens** Jewellery ☐ Yes □ M6 Other valuables (specify) Report (List of X-ray, ECG, lab reports retained with the nurse): Date Time Sign. Name Emp. No. Patient / Patient's Attendant Nurse **Unit In-Charge** 60 srt







Patient Details (1641-11)
MTB.UMA P
56/Fernalc/MHI202381+95
10/01/2024/14H2024000083
DT.G. GNANAVELU



PATIENT CLINICAL HANDOV

Date: ∖∂	IN AP	Shift: ☐ Morn	ing □Evening □Night						
S	Ventilator Periphera Ryle's Tu Urinary C	s: PEWS Score: day: line day: Right: Left be: Yes No Day atheter: Yes No Day	VIP Score:	days:					
В	Type of s Allergies On room	ROUND urgery: if any: MKDN air oxygen: Pn nts / New Symptoms in last sl	Date of surg IV fluids on fi hift:						
A	ASSESSMENT Vital Signs: Temp. T (°F) Pulse / HR: (beats/min) Respiration: (breaths/min) BP: SO D (mmHg) SpO ₂ : _ P (%) Height: Do (cms) Weight: _ T (kgs) BMI: LD LQ m Others: Pain Score: _ D Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: _ D 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								
R	Referral of Pending Pending Pending Critical vo Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections:	No. If Yes, modified care plan date	e:					
Handover ç	given by	Signature	Name R. Lulway	Emp. No.	Date	Time			
Handover t	aken by		Margthamul	n IFE	Le Jau	14-10			
Document of	endorsed	Neal	8. Nal7 NP	60 2d	10/1/20	1820			

	NU	IRSES PROGRESS NOTES		_	٠,٠٠٠
Date & Time	(Observations / Action		Signature with En	ıp, No.
10/1/04	Apm	18810N Motor	<u> </u>		<i>j</i> ->
11:00	= ph 90.		n	Din	
11-20	pri (i	entions & Owler	teel	·····	
11130	s nt pro	paration done.	evel	604	
0000	S pt W	with lab	100	froi .	
	Shiffi	y Notes			
14.00	- Datiet -All records	Shifted to cath	lab Bol		
	over to cot	h be stoff		Del 2	
		· · · · · · · · · · · · · · · · · · ·			
_					-
	Signature	Name	Emp. No.	Date	Time
Document endorsed by	New	s-well np	80 ry	10/1/24	\$ 100







Mrs.UMA P

56/Female/MHl202381495 10/01/2024/IPH2024000083

Dr.G. GNANAVELU





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

, ,1	PAIJE	NI CLINICAL F	IANDUVER	4ECOĤI) LOW MON	3E3			
Date: [di	24.	` Shift: ☐ Morn	niņģ 🗗 Évening 🔲 N	Night	() <u>(</u>	•			
S	Ventilator Periphera Ryle's Tut Urinary C	S: T2 DM OUS NOTE OF STATE OF	: Brachial	GCS: \\ \\ POD: Central line of VIP Score: \(\)	lays:	· =.			
B	On room	ROUND urgery: PTCA TOLAS fany: S'alla', & S'D, air / oxygen: DA ts / New Symptoms in last sl	AGO (ABA)	Date of surge	ery: bolilay.	_ 20M]	boes.		
A	ASSESSMENT Vital Signs: Temp: Pulse / HR: Deats/min Respiration: Deaths/min								
	Special in		29, esteq, N	a7 , 1c7	From No.	Dete	Time		
Handover gi	ivėn hy	Signature	Name	4	Emp. No.	Date 1	Time		
		· 100	Rathana Pou		0/84	10/1/084	013		
Handover ta	** , -		Maghum	Kq.	C SAL M	<u>का।/३</u> म	19-42		
Document e	ndorsed	Jail_	VAYADEN	() ()	yer ?	10/1/24	Buy		

	NU	RSES PROGRESS NOTES		
Date & Time	0	bservations / Action		Signature with Emp. No.
10/1/24				
17:10	Patient Mocey	ed Uson Couth 1	ميل	
		y Odiented, VICL		Devil 84
	McCorded the	Notes, goday pro	ATD	VE
		us alone, of pen		· .
	approch proce	duce side ishoot	2 ' · · · ·	Doniffee
	B No Bleed's	ng & No Hematom	٠ -	120
<u> </u>	DUF NS 30MI	Wy ON Plow.		10 10
17:45	post DTCA E	ry done esu- 13:	angldl	1)30 (18)
	•	Sir gion by The	P	
		smolyl, send @ a	no	- Douiles
	No compline		<u> </u>	V - 0
18:30		of Fuice NO can	rpliner	h 54
	of of continue			7008181
19:30		Deliented, elcy		
		Motes, procedure		
	Toga + Stockus	elytes eample Not	2 lofting	,)=0
		it isomple sont t		To Akan
	paluent had a ou	econ to Night duty	ustass.	The state of the s
		<u> </u>	·	
				
				
		•		
	-			
				
	Signature	Name	Emp. No.	Date Time
Document endorsed by	Jage	JAYADAUI()	000	~ 101/2120-00







Mrs.UMA P 56/Fernale/MHi202381+95 10/01/2024/IPH2024000083 Dr.G. GNANAVELU



PATIENT CLINICAL HANDOVER RECORD FOR NURSES

•		III OLINOAL.				ł	
Date: 10	ilan.	Shift: Morr	ning Evening Night			ı	
S	Urinary C	atheter: ☐ fes ☐ No Day	Hyfothyloidism GCS: 5 \ POD: Central line VIP Score: R: \ Yes \ No. If Yes, specify organi				
В	On room	urgery: PTCA to LH)	V fluids on t	gery: 10/1/ <u>0</u> 9 flow: WF-N3 30/	nal/hos Onflac		
A	ASSESSMENT Vital Signs: Temp: 97%F) Pulse / HR: The (beats/min) Respiration: 24 (breaths/min)						
R	Pending Pending Pending Critical va	medications: medication indent: lab reports / Investigations: alue alert and its corrections in nursing care plan: Yes	When, Chea Dino. If Yes, modified care plan date of Oraging Ch	e:	, i Sutid	Shi-U	
11		Signature	Name	Emp. No.	Date	Time	
Handover gi		· - W	Mathum the	02AH	14/1/2/1	7.50	
Handover ta	ken by	S. Plero-	2 Juemalatha	0211	11/1/24	7:30.	
Document e	ndorsed	Tayl	JACA Day	OON	11/1/201	#-3-	

	NI	JRSES PROGRESS NOTES	•		4	
Date & Time		Observations / Action		Signat	ure with E	mp. No.
0/1/24	NIGHT	DUTY NOTES				
@19.30						
	f pt fa	Ken Ovos forom.c	vonên			
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,	 Signature	Name	Emp. No:	<u> </u>	 Date	Time
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Mrs.UMA P

56/Female/MHI202381+95 10/01/2024/IPH2024000083





Every heart beat counts

PATIENT CLINICAL HANDOVER RECORD FOR NORSES								
Date: الرارا	24.	Shift: Morr	ning Evening D	Night	<u>. </u>	h		
S	Ventilator Periphera Ryle's Tul Urinary C	S: T2DM DLP HYPO DEWS Score: day: Il line day: Right: Duochalef be: Yes Tho Day atheter: Yes Tho Day	t: Buchal .	GCS: \5 1 POD: - Central line of VIP Score: (specify organic	days:	•		
В	On room	ROUND urgery PT(A TO LAD air / oxygerl: Roem Ale uts / New Symptoms in last s	- 901.	Date of surg	ery: 1011/24 .			
A	Vital Signs: Temp: 98 (°F) Pulse / HR: +8 (beats/min) Respiration: 80 (breaths/min) BP:116 82 (mmHg) SpO ₂ :99 (%) Height: 166 (cms) Weight: +1 (kgs) BMi: 22.6 kg/m² Others: Pain Score: 10 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NBS / CPOT Fall Risk Score: 50 Fall Risk Protocol: Low Medium High Braden Score: Minimal Risk: 23-19 At Risk-Mild Risk: 18-15 Moderate Risk: 14-13 High Risk: 12-10 Severe Risk: 9-6 Pressure Ulcer Scale for Healing (PUSH): Yes No NA Wound Dressing done: Yes No NA Current diet: 10 M dight Drains: Drains: Current diet: DM dight Drains: Drains: Current diet: DM dight Drains: DM dight Drains: DM dight Drains: DM dight Drains: DM dight DM							
R	RECOMMENDATION Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: Critical value alert and its corrections: Changes in nursing care plan: Yes No. If Yes, modified care plan date: Pending follow-up orders: Special instructions if any:							
		Signature	Name		Emp. No.	Date	Time	
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Mrs.UMA P 56/Female/MHI202381495 10/01/2024/IPH2024000083

Dr.G. GNANAVELU





PATIENT CLINICAL HANDOVER RECORD FOR NURSES

	· Alle	IVI OLINIOAL I	IANDOVEN NEOOM						
Date: [\[124	Shift: Morr	ning Evening Night						
S	NEWS / F Ventilator Periphera Ryle's Tul	s: CAD → DV D PEWS Score: O day: Il line day: Right: Lef be: □ Yes ☑ No Day atheter: □ Yes ☑ No Day		days:		. · ·			
В	On room	ROUND Wrgery: PTLAD if any: NKDA air / oxygen: ON 800 W ots / New Symptoms in last s	IV fluids on t	gery: tol124-					
A	ASSESSMENT Vital Signs: Temp: 97-9(°F) Pulse / HR: 80 (beats/min) Respiration: 10 (breaths/min) BP: 10 70 (mmHg) SpO ₂ : 98 (%) Height: 16b (cms) Weight: 11 (kgs) BMI: 22 6 g/m² Others: Pain Score: 0 0 Pain Scale used: PIPPS / CRIES / FLACC / Wong-Baker FACES Pain Rating Scale / NRS / CPOT Fall Risk Score: 50 Fall Risk Protocol: 0 Low Medium High Braden Score: 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): 9-6 No NA Wound Dressing done: 9-6 No NA Current diet: 9 Moderate Risk: 9-6 Drains:								
R	Referral of Pending Pending Pending Critical va Changes Pending	medications: medication indent: lab reports / Investigations: alue alert and its corrections: in nursing care plan: Yes, follow-up orders:	No. If Yes, modified care plan dated to the source.	e:					
Handover g	given by	Signature	Name	Emp. No.	Date	Time			
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	NURSES PROGRESS NOTES	
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ulilan	Evening duty notes	
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	Mooning duty Staff in a	flay 0.05
	patient handing over taken from Mooning duty Staff un a hemodynamically stable Condition	
13:00	Vital Signs Checked & Recorded	-thy
		डिंग्ड र
4:00	Due deugs ace given as per	Hay-
	lalua Chailt	"etos
15.00	- patient was Stable & NO	
<u> </u>	compaints	
16.00		
	-> Tomorrow Plan dus Charge.	16/4
18.30	=> vital Signs Checkode, recording	Dipis —
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	the night duty stall	Oths
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Mrs.UMA P

56/Female/MHJ202381+95 10/01/2024/tPH2024000083

Dr.G. GNANAVELU





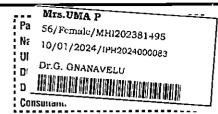
PATIENT CLINICAL HANDOVER RECORD FOR NURSES

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Date:	1/20	Shift: Morr	ning □Evening ☑Wight					
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A	ASSESSMENT Vital Signs: Temp@ff_&_CF Pulse / HR:SO(beats/min) Respiration:&O(breaths/min) BP:							
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)☐No. If Yes, modified care plan da	te:				
	Pending	follow-up orders:	0 (
	Special i	nstructions if any: Plan	alls stomm	wyo .				
	<u></u>	Signature	Name	Emp. No.	Date Time			
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	PATIE	INT CLINICAL H	IANDOVER RECOR	D FOR NUF	RSES	!		
Date:	2/1/9	2 Shift: ☐ Morr	ning Evening Night					
S	Ventilator Periphera Ryle's Tul Urinary C	PEWS Score: day: al line day: Right: be: Yes No Day atheter: Yes No Day	/: VIP Score:	5/5				
B		urgery:	Date of surg IV fluids on fl hift:	-				
A	ASSESSMENT Vital Signs: Temp: 48 (F) Pulse / HR: 80 (beats/min) Respiration: 90 (breaths/min) BP: 100 (80 (mmHg) SpO ₂ : 26 (%) Height: 100 (cms) Weight: 110 (kgs) BMI: 22 (cms) Others:							
RECOMMENDATION Referral doctors: Pending medications: Pending medication indent: Pending lab reports / Investigations: Critical value alert and its corrections: Changes in nursing care plan: Yes No. If Yes, modified care plan date: Pending follow-up orders: Special instructions if any:								
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NURSES PROGRESS NOTES						
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ADULT NURSING CARE PLAN

Mrs.UMA P

56/Female/MH1202381+95 10/01/2024/IPH2024000083





		, 		
Initial Date: 16 1 24	Time:	Modified Date: Time:		
Reason for Modification:		Diagnosis: Toom aysupidem'i q		
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION ☐ Keep NPO	Patient will have adequate nutrition with no nausea and vomiting	Provide Prescribed diet on time Encourage patient to consume the served meal	M	
☐ Regular Diet ☐ Others:	Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	Record amount of food consumed	EPT ON DM diet	12047
. 1			NP+ had dry diet	D.R.h.
OXYGENATION Room Air Nasal Cannula / High Flow O ₂ Mask BiPAP / CPAP	No other respiratory abnormalities Patient respiratory rate will remains	□ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises □ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order □ Utilise pulse oximetry to check O₂ saturation and pulse rate	M	
☐ 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 	pt-on RA E Sp02-99%.	Dough
· · ·	· · · · · · · · · · · · · · · · · · ·	□ 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 pton swom ons	@ 02HM1
FLUID & ELECTROLYTES Gral Intravenous	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	м	
☐ Enteral Nutrition ☐ Parenteral Nutrition ☐ Others:			E	
		Monitor BP for orthostatic changes .	PH ON FUF NS N 30 All hous	Playses

Pàtient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign Initia
MOBILITY Mobile / Immobile Walk with assistance Physiotherapy Others:	□ Patient will mobilize freely □ Patient will perform physical activity independently or within limits of disease □ P_tient will use safety measures to minimize potential for injury □ Patient will demonstrate the use of adaptive devices to increase mobility	□ Encourage regular ambulation ROM exercise □ Apply Anti-Embolic stocking / SCD □ Evaluate the need for assistive devices □ Assess the safety of the environment □ Consider the need for home assistance (e.g., physical therapy, visiting nurse) □ Note for progressing thrombophlebitis (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature)	M Pt ON Emmobilizy From Bed Nest	120 CD 211
ELIMINATION Catheter, bedpan, urinal Nasogastric tube Bowel movement Urination Others:	Patient will have normal elimination pattern Patient will control of urinary in-continence or urinary retention, control of bowel incontinence, and regular elimination patterns	□ Encourage fluid intake □ Encourage fibre diet intake □ Encourage early ambulation □ Report any abnormalities to physician □ Observe voiding accessories as foley's / silicone catheter □ Check placement before feeding □ Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order and follow proper protocol □ Check for malena / constipation / urinary retention	Political politi	Py
SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment 'HAPI OPI GRADES OF PRESSURE INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased Intermittent Assisted Dermatitis Pressure injury / blisters site care given Others:	Patient will maintain normal healing status Patient will discharge with intact skin integrity	 Minimize / Eliminate friction and shear Minimize pressure (off-loading) with special beds Make sure wrinkles free bed / comfort surfaces and devices Early skin inspection and treatment Keep position changing 2 hourly and manage pain Manage moisture, clean and dry skin Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care 	M Sicin Denterity E FATON (1) N Spin is ntegority	Doe O2h

		! _		1 ,
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
☐ Bed-Bath ☐ Assist-Bath ☐ Self-Care ☐ CBD Care	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs Patient will recognize individual weakness or needs	□ Encourage patient to do daily bathing and oral hygiene □ Change patient's gown daily □ Encourage hand hygiene □ Consider the patient's need for assistive devices □ Apply moisturizing solution	M E Pt-Clean Squall Gro much	nunger 7.
			N Fron clans	Q ozny
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	
			E Pt 20 Band 6 Dy dine checked	Dougar,
			N Apron p	्र ००० ११
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 Dt cornelorfeble Passifier	Dougsum
A. A. A. A. A. A. A. A. A. A. A. A. A. A		<u> </u>	N & poten comfortable Sleep	D2HH
OBSERVATION Vital Signs GCS Blood Sugar Others:	Patient will have normal range of vital parameters		М	
			E DE Hourd VICG	Pougen
			N form VIS Chelled growrolld	PAH 02AH
SPIRITUAL SUPPORT Spiritual Needs	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	м	
			E PA N Psychologian	Buffer
			N - Apten Paylus haggar support given	62HH

'Patient Specifi Probl ems / Ne		Measurable Goals	-	Nursing Interventions		Evaluation	-	Sign & Initials
COMMUNICAT Verbal Non-verbal Sigh language	ION	Patient will communi with positive feedbac	municate effectively dback Introduce the care giver Encourage the use of call bell Obtain interpreter if needed No negative speaking about the patient's condition		e condition	M	o what	
Others:		÷ .		or prognosis in the patient's presence	3 CONTURION		romen i afiling	Done
	•					N Epton	anocati on	ู่ อันหา
SPECIAL INTERVENTIONS Medication Wound care Isolation Ostomy Care Blood y Blood products transfusion Fluid tapping DVT Management		☐ 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 		M		,
				and explain to the patient / family ☐ Check for cross matching and typing, to ensure compatibility ☐ Practice strict asepsis while transfusing blood or blood products and fluids		E medicati	nister or so letact	Dugt
Others:		•		Monitor DVT score and continue treatment as per doctors order		N spaton medication groven aspoil oliving the		D244
1	Signature		Name		Emp. 1D		Date	Time
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ADULT NURSING CARE PLAN

Mrs.UMA P

56/Female/MHl202381+95 10/01/2024/IPH2024000083

Dr.G. GNANAVELU





Initial Date: WINDY	Time:8.00	Modified Date: Time:		
Reason for Modification:		Diagnosis: TODN/ CALCUFIC LA	D S DEA DISTANT /G	LV-FON
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
NUTRITION Keep NPO Regular Diet Others:	Patient will have adequate nutrition with no nausea and vomiting Patient will consume daily nutritional requirements in accordance to his activity level and metabolic needs	Provide Prescribed diet on time Encourage patient to consume the served meal Record amount of food consumed	M pt had sugalan diet E pt had DM diet	Hout
1.13			NPT had DIE	坐.
OXYGENATION Proom Air Nasal Cannula / High Flow O ₂ Mask BIPAP / CPAP Ventilator	Patient will have normal O₂ saturation Patient ABG levels will return to and remain within normal limits No other respiratory abnormalities Patient respiratory rate will remains within established limits	□ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises □ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order □ Utilise pulse oximetry to check O₂ saturation and pulse rate □ If any O₂ abnormalities detected inform immediately to	M Pt On Room APR 8102-98-1	97.A
☐ 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	e on soom our	they ow
`		□ Note for changes in level of consciousness □ Send sputum for culture and sensitivity based on physician order □ Maintain clear airway by suctioning or encouraging patient with successful coughing	n pt was stable	Son
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+ intake well	<u>est</u>
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 Plo Chart Maintained	Hay
		- Monte. 2. Tot officerate officings	N Ilo chart	de

Pàtient Specific Sian & **Nursing Interventions** Measurable Goals Evaluation Problems / Needs Initials Patient will mobilize freely MOBILITY Encourage regular ambulation ROM exercise basilitan 1/2 x / M Mobile / Immobile Patient will perform physical Apply Anti-Embolic stocking / SCD Walk with assistance activity independently or within Evaluate the need for assistive devices ☐ Physiotherapy limits of disease Assess the safety of the environment Others: □ Putient will use safety measures Consider the need for home assistance pt mobilized well to minimize potential for injury (e.g., physical therapy, visiting nurse) Patient will demonstrate the use of ☐ Note for progressing thrombophlebitis adaptive devices to increase mobility (e.g., calf pain, Homan's sign, redness, localized swelling, a rise in temperature) Pt Mobilized Nathanimile (h) +9 Encourage fluid intake
Encourage fibre diet int **ELIMINATION** Patient will have normal elimination Catheter, bedpan, urinal Encourage fibre diet intake pattern ☐ Encourage early ambulation ☐ Report any abnormalities to p ☐ Nasogastric tube □ Patient will control of urinary ☐ Bowel movement in-continence or urinary retention. Report any abnormalities to physician ☐ Urigation ☐ Observe voiding accessories as foley's / control of bowel incontinence. Pt had normal ☐ Øthers: and regular elimination patterns silicone catheter ☐ Check placement before feeding☐ Aspirate NG tube, check colour / consistenct Hest elimination Patteen / volume / Hemetemesis as per doctors order and follow proper protocol ☐ Check for malena / constipation / urinary retention elimination pattern Sen Minimize / Eliminate friction and shear
Minimize pressure /c# /--M & wintown Monnol

Som Entoquity SKÍN INTEGRITY ☐ Fatient will maintain normal Maintain normal skin integrity _healing status Minimize pressure (off-loading) with special beds ☐ Make sure wrinkles free bed / comfort surfaces Pressure points site Patient will discharge with intact assessment skin integrity and devices ☐ HAPI ☐ OPI ☐ Early skin inspection and treatment Keep position changing 2 hourly and manage pain
Manage moisture, clean and dry skin K/O **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-Pressure injury / blisters site N Pt had normal _skin Integritt. 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	M Pt Clean & wall E Pt groomed well N Dt groomed well	that The
				OK.
SAFETÝ Check ID Hand IV care	Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails	m l+ ID bound lowered	A COLD
CENTRAL LINE Side rails Others:		Provide proper invasive line care Keep bed locked and low at all time Educate care providers to be the patient	E ID band present	Hay
,	* £	Follow restrain policy (if needed)	N It bound prepart	
COMFORT AND SLEEP Pain Control	Patient will have comfortable sleep Patient will verbalize / or through	☐ Provide clean calm and restful environment☐ Provide privacy at all time	M & Emonido cantendopo	Bu
☐ Sleep Patterns ☐ Others:	behavior about pain relief and adequate sleep	☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	E	
			N	_
OBSERVATION Vital Signs GCS Blood Sugar	Patient will have normal range of vital parameters	☐ Monitor vital signs regularly ☐ Monitor vital signs on ordered time ☐ Assess physically for any abnormality ☐ Inform doctor if there is any abnormality	M P4 V/2 Chackad E,	Don
Others:		☐ Monitor GCS of patient ☐ Determine and treat the underlying cause of altered LOC ☐ Regular blood sugar monitoring as per doctors order	E Patient Vital Signs	Hay
			NPT Vital signs are stable.	Jour.
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness	☐ Pray or encourage the patient to pray ☐ Use inspirational words ☐ Respond to spiritual needs as they arise	M P+ Pucoida Ssychologia	J Q
☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	Patient will maintain normal psychological pattern	☐ Evaluate spiritual needs☐ Encourage verbalization of feelings / therapeutic touch☐ Provide empathy and reassurance☐	E	
			N	

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Patient Specifi Problems / Ne		Measurable Goals		Nursing Interventions		Evaluation		Sign & Initials
COMMUNICAT Verbal Non-verbal	rion	with positive feedback		Introduce the care giver Encourage the use of call bell Obtain interpreter if needed		w bt cours	råtreviru Vacu	& OTY
Sigh language Others:		-		No negative speaking about the patient's or prognosis in the patient's presence	s condition	E Pt Com	municated well	Hay
		,				N		
SPECIAL INTERVENTIONS Medication Wound care Isolation Octobry Care		/	Follow hospital polices and protocols of isolation		1 9	M Pt medicerlien given		
☐ Isolation ☐ Ostomy Care ☐ Blood / Blood products transfusion ☐ Fluid tapping ☐ DVT Management				and explain to the patient / family Check for cross matching and typing, to compatibility Practice strict asepsis while transfusing to blood products and fluids		E Due o	lengs are	Hay
Others:				☐ Monitor DVT score and continue treatme as per doctors order	ntinue treatment N DU St Veu		drigs are	Jen
	Signature		Name		Emp. ID		Date	Time
Endorsed by		vee	3.	wiPnP	ඉ ව) > -	celelou	(<i>6 p</i> 20
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ADULT NURSING CARE PLAN

____JMA P

56/Female/MHl202381+95 10/01/2024/IPH2024000083

Dr.G. GNANAVELU





Initial Date: // タ、1、2の	フリ Time: 8ょっこ・	Modified Date: Time:					
Reason for Modification:	(Diagnosis: しょうーりょう					
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	MP had diet	0241			
			N				
OXYGENATION Room Air Nasal Cannula / High Flow O Mask BiPAP / CPAP	☐ No other respiratory abnormalities☐ Patient respiratory rate will remains	□ Encourage chest physio / deep breathing and coughing exercise / Spirometry exercises □ Provide well-ventilated environment / respiratory medications / Oxygen as per doctors order □ Utilise pulse oximetry to check O₂ saturation and pulse rate	M Pot on Room	£33)			
☐ BiPAP / CPAP ☐ 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 	Pt ou Room	(#TCQ			
		□ 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				
ELUID & 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 5 10 montos E 2 Cro Censi Monntosire N	8-4			

	Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
	MOBILITY ☐ Mobile / Immobile ☐ Walk with assistance ☐ Physiotherapy ☐ Others:	☐ Patient will mobilize freely ☐ Patient will perform physical activity independently or within limits of disease ☐ Putient will use safety measures	☐ Encourage regular ambulation ROM exercise ☐ Apply Anti-Embolic stocking / SCD ☐ Evaluate the need for assistive devices ☐ Assess the safety of the environment ☐ Consider the need for home assistance	M DSS i 87	P. 17
		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	
	5 / .			N	
	EtiMination 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 D partie	
	Others:	and regular elimination patterns	silicone catheter Check placement before feeding Aspirate NG tube, check colour / consistenct / volume / Hemetemesis as per doctors order	E	
ستد	,		and follow proper protocol Check for malena / constipation / urinary retention	N	
	SKIN INTEGRITY Maintain normal skin integrity Pressure points site assessment HAPI OPI GRADES OF PRESSURE	☐ Patient will maintain normal healing status ☐ Patient will discharge with intact skin integrity	□ Minimize / Eliminate friction and shear □ Minimize pressure (off-loading) with special beds □ Make sure wrinkles free bed / comfort surfaces and devices □ Early skin inspection and treatment □ Keep position changing 2 hourly and manage pain □ Manage moisture, clean and dry skin	M	
	INJURY GRADE 1 GRADE 2 GRADE 3 GRADE 4 Unstageable Deep Tissue Injury Healing Status PUSH Decreased PUSH Increased		Maintain adequate nutrition and hydration Proper application of medications and dressing Follow doctors and TVN order properly Monitor the healing status Educate patient and family members about further skin care	E	
I	☐ Intermittent Assisted ☐ Dermatitis ☐ Pressure injury / blisters site care given ☐ Others:			N	

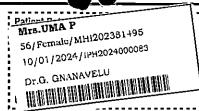
Patient Specific Problems / Needs	Measurable Goals	Nursing Interventions	Evaluation	Sign & Initials
HYGIENE Bed-Bath Assist-Bath Self-Care CBD Care (if present) Others:	Patient will stay clean and well-groomed Patient will demonstrate lifestyle changes to meet self-care needs Patient will recognize individual weakness or needs	 ☐ Encourage patient to do daily bathing and oral hygiene ☐ Change patient's gown daily ☐ Encourage hand hygiene ☐ Consider the patient's need for assistive devices ☐ Apply moisturizing solution 	M grooned well	2312
			N	
SAFETY Check ID Hand IV care EJV	Patient will have no life-threatening situations	☐ Check the identity with ID band before any interaction with the patient ☐ Raise side rails	M DD bond	Carlo Carlo
CENTRAL LINE ☐ Side rails ☐ Others:		☐ Provide proper invasive line care ☐ Keep bed locked and low at all time ☐ Educate care providers to be the patient	E	
		Follow restrain policy (if needed)	N	
COMFORT AND SLEEP	☐ Patient will have comfortable sleep☐ Patient will verbalize / or through	☐ Provide clean calm and restful environment☐ Provide privacy at all time	M	
☐ Sleep Patterns ☐ Others:	behavior about pain relief and adequate sleep	☐ Monitor pain scale / sleep pattern ☐ Provide pharmacological and non-pharmacological therapy	E	
	/		N	
OBSERVATION Vital Signs GCS Blood Sugar	Patient will have normal range of vital parameters	Monitor vital signs regularly Monitor vital signs on ordered time Assess physically for any abnormality	m us is stable	238)
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	
			N	
PSYCHOLOGICAL / SPIRITUAL SUPPORT Spiritual Needs	Patient will achieve spiritual needs Patient will be able to control his feeling toward his illness	Pray or encourage the patient to pray Use inspirational words Respond to spiritual needs as they arise	м	
☐ Beliefs / Values / Customs ☐ Anxiety and Copying Pattern ☐ Identify Stressors ☐ Others:	Patient will maintain normal psychological pattern	Evaluate spiritual needs Encourage verbalization of feelings / therapeutic touch Provide empathy and reassurance	E	
			N	l

Patient Specif Problems / Ne		Measurable Goals	•	Nursing Interventions	•	Evaluation		Sign & Initials
COMMUNICA Verbal Non-verbal Sigh language		Patient will communic with positive feedback	cate effectively k	☐ Introduce the care giver ☐ Encourage the use of call bell ☐ Obtain interpreter if needed ☐ No negative speaking about the patier	د المال ما د المال	m Good	Con mi	750
Others:				or prognosis in the patient's presence	n s condition	E		
						N .		
SPECIAL INTERVENTIONS Medication Wound care Isolation Ostomy Care Blood / Blood products transfusion Fluid tapping DVT Management		☑ To manage on time		Double check for high alert medication Doserve and report any medication real Provide proper measures of wound ca Follow hospital polices and protocols of	action re	Mural gire		(2)
				and explain to the patient / family Check for cross matching and typing, compatibility Practice strict asepsis while transfusing blood products and fluids		E		
Others:	GIR.			Monitor DVT score and continue treatment as per doctors order		N		
	Signature		Name		Emp. ID		Date	Time
Endorsed by		Noo		s. palana	න ව	out.	plilor	16 ps



(A Unit of United Alliance Healthcare Pvt Ltd)





MHI/NUR/2022/045

Every heart beat coupts Date: 10

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK Time:									
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	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. Parely Moist Skin is usually dry, linen only requires changing at routine intervals		H	3		
ACTIVITY degree of physical activity	Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	ا ۸۸	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	Ŋ	,	}		
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	الع	ع	3		
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3. No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. N or chair		23	16 18	3		
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:	K	7	1		





Mrs.UMA P

56/Female/MH1202381495 10/01/2024/IPH2024000083

Dr.G. GNANAVELU



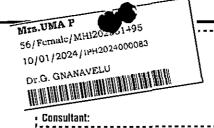


Every heart beat counts (A Unit of United Alliance Healthcare Pvt Ltd) Date: BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK Time: 4. No Impairment SENSORY 1. Completely Limited 2. Very Limited 3. Slightly Limited PERCEPTION Unresponsive (does not moan, flinch,or Responds only to painful stimuli. Cannot Responds to verbal commands, but Responds to verbal grasp) to painful stimuli, due to diminished commands. Has no sensorv ability to respond communicate discomfort except by cannot always communicate discomfort level of consciousness or sedation OR deficit which would limit meaning-fully to moaning or restlessness OR has a or the need to be turned OR had some pressure-related limited ability to feel pain over most of body sensory impairment which limits the ability sensory impairment which limits ability to ability to feel or voice pain or discomfort to feel pain or discomfort over 1/2 of body feel pain or discomfort in 1 or 2 extremities discomfort 4. Rarely Moist 3. Occasionally Moist 1. Constantly Moist 2. Very Moist MOISTURE Skin is kept moist almost constantly by Skin is often, but not always moist. Linen Skin is occasionally moist, requiring an Skin is usually dry, linen only degree to which perspiration, urine etc. Dampness is must be changed at least once a shift extra linen change approximately once a requires changing at routine 3 skin is exposed detected every time patient is moved or intervals to moisture turned 1. Bedfast 2. Chairfast 3. Walks Occasionally 4. Walks Frequently Confined to bed ACTIVITY Ability to walk severely limited or non-Walks occasionally during day, but for very Walks outside room at least degree of existent. Cannot bear own weight and / of short distances, with or without twice a day and inside room 3 physical activity must be assisted into chair or wheelchair assistance. Spends majority of each shift at least once every two hours in bed or chair during waking hours 2. Very Limited 4 No Limitation 1\Completely Immobile 3. Slight Limited MOBILITY Does not make even slight changes in body Makes occasional slight changes in body Makes frequent through slight changes in Makes major and frequent ability to change or extremity position without assistance or extremity position but unable to make body or extremity position independently changes in position without and control body frequent or significant changes assistance position independently 3. Adequate 1. Very Poor 2. Probably Inadequate 4. Excellent Eats most of every meal. Never eats a complete meal. Rarely eats Rarely eats a complete meal and generally. Eats over half of most meals. Eats a total of more than any food offered. Eats 2 servings eats only about 2 of any food offered. 4 servings of protein (meat, diary Never refuses a meal. NUTRITION products) per day. Occasionally will refuse or less of protein (meat or dairy products) per Protein intake includes only 3 servings of Usually eats a total of 4 or usual food day. Takes fluids poorly. Does not take a meat or diary products per day. a meal, but will usually take a supplement more servings of meat and intake pattern liquid dietary supplement OR Is NPO and / or Occasionally will take a dietary when offered OR is on a tube feeding or diary products. Occasionally maintained on clear liquids or IV's for more supplement TPN regimen which probably meets most eats between meals. Does than 5 days of nutritional needs not require supplementation 3. No Apparent Problem 1. Problem 2. Potential Problem Moves in bed and in chair independently and has sufficient muscle Requires moderate to maximum assistance Moves feebly or requires minimum/ 8 in moving. Complete lifting without sliding assistance. During a move skin probably strength to lift up completely during move. Maintains good position in bed FRICTION against sheets is impossible. Frequently slides to some extent against sheets. & SHEAR slides down in bed or chair, requiring chair, restraints or other devices, 20 **TOTAL SCORE** frequent re-positioning with maximum Maintains relatively good position in chair assistance. Spasticity, contractures or or bed most of the time but occasionally Initial & Emp. No. agitation leads to almost constant friction slides down of Staff Nurse: Initial & Emp. No. Score Interpretation: Minimal Risk: 23 - 19, At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6

of Sr. Staff Nurse:







MHI/NUR/2022/045

Medway

Heart
Institute

Every heart beat counts

Date: 1

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

	BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK Time:										
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	4						
MOBILITY ability to change and control body position	Completely immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	4						
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	i.					
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3-No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair TOTAL SCORE Initial & Emp. No. of Staff Nurse:		3						
Score	Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6 Initial & Emp. No. of Sr. Staff Nurse:										







Prient Details (Affix Label here)

Mrs.UMA P

56/Fcmalc/MHI202381+95

10/01/2024/IPH2024000083

Dr.G. GNANAVELU

MHI/NUR/2022/052

Heart Institute

Every heart beat counts

PAIN RE-ASSESSMENT & MONITORING CHART

						<u></u>	
	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.
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14:00	olio	No Pain	ali)	M;]	Mil	burgas	Topoor
18:00	0/10	M pain	Mi)	Nil	Nil	Davit 22	Joefoon
(9:00	ollo	No Pain	N;)	1:20	NI)	Son ya	Joefoor
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	Date & Time	Pain Score	(dull, achy burning	ain Character , sharp, stabbing, shooting, , referred / radiant pain)	Duration	Location / Site		Interventions		Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.		
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	1-00	0/0	Ω	10 Pain	1	-	~			Pann	Jackpool		
	2-00	e) v	n	10 Pain	1	_	_		, · · · · · · · · · · · · · · · · · · ·	D O2AH	Joules		
	3.00	8	N	o fain	1	1				Q v	Joeldon		
Ì	`	PAIN SCALES											
	PIPPS 4 (28 weeks to ≤ 38 weeks) 6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort m >12 = Moderate to severe pain - Phar				le comfort me			ř. ·	J W. C.	•	, 53°		
ı	(38 we	CRIES eks - 2 m	onths) ,					ore of 10 is possible. If the CR ated for a score of 6 or higher.			,		
١		ACC Sca nths - 7 y		0: Relaxed & comfortable	e, 1-3: Mild di	llscomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both							
	Wong-Baker FACES Pain Rating Scale (7 years - 12 years) O 2 4 No Hurts Hurts Little Bit More			6 Hurts Even More	8 10 Hurts Whole Lot Worst	Numerical Rating	Scale (age model) 4 5 6 Moderate	7 8	9 10				
	Observa	cal care f ition Tool itor / com	(CPOT)	COMPLIANCE WITH VEN	Absence of matternation (in the state of the	ovements or normal p ntubated patients): 0 nts): 0 - Talking on nor nse, Rigid, 2 - Very Te	position, 1 - Protection, 2 - Re - Tolerating Ventilator or Mov rmal tone or no sound, 1 - Sig nse, Rigid	stlessness / Agitation rement , 1 - Coughing but tolerat ghing, Moaning, 2 - Crying out, s		rentilator (or)			
	Non-pharmacological Interventions Distraction: A - Relaxation-conducive e Cutaneous Stimulation and massage: Thermal Theraples (no longer than 15					E - Positioning; F - Reto 20 minutes): G - Co	ubbing / Massage the skin old application; H - Hot applic		Individual Couns	eling; L - Family	counseling		
	Pharmac	ological i	nterventio	ns as per doctor's prescrip									









Mrs.UMA P

56/Female/MHI202381495 10/01/2024/IPH2024000083

Dr.G. GNANAVELU



MHI/NUR/2022/052



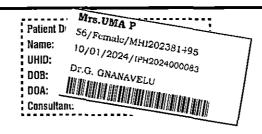
PAII	N RI	E-ASSESSMENT	& MC	NITORING	CHART	Every heart bear	
Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial 1	nior Staff nitial &) mp. No.
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18:00	olw	No pain		_	_	Hay 1	vise





Use & Parin Time Score Score	?"												
PAIN SCALES PipPs	Date & Time		(dull, achy,	sharp, stal	bbing, shooting,	Duration	Location / Site		Interventions	3	,		
PIPPS (28 weeks to ≤ 39 weeks) For less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures > 12 = Moderate to severe pain - Pharmocological intervention The CRIES scale is used for infants > han or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, The CRIES scale is used for infants > han or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, The CRIES scale is used for infants > han or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, The CRIES scale is used for infants > han or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, The CRIES scale is used for infants > han or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, The CRIES scale is used for infants. > han or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, The CRIES scale is used for infants. > han or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, The CRIES scale is used for infants. > han or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, The CRIES scale is used for infants. > han or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, The CRIES scale is used for infants. > han or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, The CRIES scale is used for infants. > han or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, The CRIES scale is used for infants. > han or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, The CRIES scale is used for infants. > han or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, The CRIES scale is used for infants. > han or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, The	80°00	0/0		No	Pain	_	ļ					Jon	pool
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Pharmacological Interventions as per doctor's prescription				Cutaneo Thermal	us Stimulation a Therapies (no lo	ind massage: onger than 15	: E - Positioning; F - F to 20 minutes): G - C	tubbing / Massage the skin old application; H - Hot applic	cation; I - Shortwave		; vidual Counse		
	Pharmac	ological I	nterventio	s as per d	octor'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

	Date	Itali	11/2/21	12/124			T -	
	Time	11.20	\$,00	700				
S. No.	PARAMETERS							
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	Ø	0	0				
2	Bedridden recently >3 days or major surgery within four weeks	0	0	0	:			
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0	0	0				
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	0	0	0				
5	Entire leg swollen (Assess for both legs)	Ø	0	Ø				
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)	Ø	0	Ø				
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)	Ø	0	٥				
9_	Previously documented DVT (Assess for both legs)	0	0	0				
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.	0	0	0				
	FINAL SCORE	8	0	0				
Low R	isk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	v DO	1-0°	ل دعر				
	DVT prophylaxis started	☐ Yes ☑ No	∐Yes 1☑1√16	□ Yes □ No	□ Yes □ No	□ Yes □ No	☐ Yes ☐ No	☐ Yes ☐ No
	Signature & Emp. No. of RN	Ster	R Si	Some I				****
	Signature & Emp. No. of Sr. RN	Noch	1989	Non				



Medway Hospitals

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



MIS.UMA P 56/Female/MH1202381495 10/01/2024/PH202400083 Dr.G. GNANAVELU

MHI/NUR/2022/046



Where heart beat never stops..

MODIFIED MORSE FALL RISK ASSESSMENT CHART

									ł	_
Variables	Date	ilai	Pylan	19/1/24	ulibr	 	Milipu	27/1/2	1	
	Time	0811	14.3°	21-00	8.00	19:00	20.00	& 50		
History of falling	No	10	(4)	(o)	(0	م	0_	_ 0	0
(immediate or within 6 months)	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis	No	0	0	1	گ	0	0	0	0	0
(≥ 2 medical diagnosis)	Yes	15	(5)	15	(15)	N5/	,15m	15⁄	15	15
Intravenous Therapy /	No	8	0	0	0_	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	20	(0)	/20	(20)	•20	_201	20⁄	20	20
AMBULATORY AID]-			X						
None / Bed Rest / Nurse Assist		9	(6)	(o)	(0)	4 /	_0,	0'	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT		_	~	0	0	/			/	
Normal / Bed Rest / Wheel Chair		9	(0)	(O)	6	A	-0	0/	0	0
Weak		² 10	`10	ALL Y	10	10	10	10	10	10
Impaired .		20	20	20	20	20	20	20	20	20
MENTAL STATUS									•-	
Oriented to own stability		ø	©		(B)	20	_0	0/	0	0
Overestimated or forgets limitations		15	15		15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives, immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No Yes	0 / ¹⁵	0 (13)	15	0 (15)	0 18	0 15	0	0	0 15
Total Score		ap	80	50	50	50	SO	50		
Low Risk (0 - 24)		`	/							
Medium Risk (25 - 44)			4							
High Risk (45 or above)		Χ.	1	1		V			-	-
Signature & Emp. No. of RN			BY TY	Day.	8	+ Bits	John.	X557)	
Signature & Emp. No. of Sr. RN		T/	PA.	N	Roy	Noor	Ners	10000		
	-	0900 -	24. Low	Risk; 2	5 - 44: N	ledium	Risk; 45	or abov	e: High	Risk

Time Low Risk Interventions (0-24) Familiarize the patient with the immediate surroundings Remind the patient to use call bell before getting out of bed Keep the two side rails in the raised position at all times for all patients regardless of age Keep the patient's bed in the low position at all times for all patients regardless of age Keep the patient's bed in the low position at all times except during procedure Tracht fall-prevention techniques, such as sitting up for a moment before rising from the bed Bed wheels should be locked Encourage family participation in the patient's care Ensure latifloor of the batthroomis dry and not slippery Review medications for potential side effects that can promote fails Use anafety batts during movement in wheelchair The patients are not ambulated by themselves. They are to be ambulated only with assistance Medium risk interventions Medium risk interventions Tre yetiow fall fails and in the de and Wheel chair / Stretcher Make sure that proper transfer precautions are instituted for heavy or deblisted patients in a bed or wheel chair or on a tollate seat User restraints and bed monitions as ordered by the doctor Allow the patient to arrobuste only with assistance Consider peak effects of the medicatrons that effects level of consciousness, gait and elimination when planning patients care Do not leave patients unattended in diagnostic or treatment areas Accompany the patient while going to bathroom Advice the patient to use grab bars near the tollet, bathtub, and shower Make sure the family and other visitors understand the restrictions mentioned above High-risk interventions (55-a bove) Apply all the low and medium risk interventions Time red all risk tag in the bed, wheave reach (if appropriate) Unand bedomes and the week the patient while going to bathroom Advice the patient while going to bathroom Advice the high-risk patients in a room close to the nurses' station Answer these patients call balls as quickly as possible Provide a commedot at bedside (if	INTERVENTIONS	Date	1/04	10/1/1	918	11/1/24	11/1/20	الإارار	2/12	7	
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Signature & Emp. No. of RN	Its		ع صا								
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Signature & Emp. No. of Sr. RN				W.Z	- 0 1)	200	100	0	200	<u></u>	







Mrs.UMA P 56/Female/MHI202381495 10/01/2024/IPH2024000083

Dr.G. GNANAVELU







PATIENT AND FAMILY EDUCATION RECORD

Assessment To be		by cond				olines. U				v				<u>.</u>
Barriers to	Le	arning								Plan t	o A	ddr	es	s Factors
None		Vision	/ He	arin	g lin	nitations	i		Ē	Use	of Ir	ıterp	rete	er
Limited Reading Abilities		Physic	al b	arrie	rs				☐ Educate family					
Religious / Cultural Factors	s / Cultural Factors										e			
Congnitive Limitations - unable to		Low m	otiv	ation	/ de	esire to	learr	,	Ē	Write	ten 1	nstu	ctio	ns
understand and follow directions														
Completed By : Date 1011 24 Tin	ne	8/11	Ø)	<u> </u>	lurs	e Signa	ture	:_		Y	~			
										<i>100</i> 0	1			
Learning Record	_												_	- 1
Need		Date		/isit	1	Date		/isit	2	Date	M \	/isit	3	Signature
		عرااحا	L	Р	0	اداراه	Ŀ	Р	0	12/11	L	Р	0	
Disease												<u>_</u>	L	Doctor
Information on			O	L.	. /			آ ا	.,			 		1. frz fe
Disease / Diagnostics			Y	Q			9	Ø)	V		P	OS	\vee	Conn
☐ Treatment				<u> </u>	L,									
Medications			V	OD)	\bigvee		P	O)	V		2	ØΣ	\triangle	Doctor / Nurse
☐ Information on Safe and			1								υ			1
Effective use of medicines	-			obi								lacksquare		
Information on drug / drug and			IY	זעטו	٧		P	OP	ν			_ ا		
drug / food interactions						1					D	08	$ \vee $	
Discharge Medications	_		Ü	α	\Box		P	<u>a</u>	V		P	\bigcirc	V	COL
Surgical Instructions			10	^ (<i></i>	_				U	Ļ		Nurse O
Pre - Operative Instructions			17	06	\square		P	Q)	V	_	p	T)	\geq	
Post - Operative Instructions (Wound / Dressing Care)			'								V			
												╙		<u> </u>
Pain Management ✓ Reporting of pain					Н			igdash				┡		Nurse
Pain Management					\vdash					 -	-	\vdash	\vdash	
Safe and effective use of medica				_	Н			\vdash				<u> </u>	\vdash	Oneton / Marra
Equipment (if required)	••													Doctor / Nurse
Name of Equipment					\vdash					-		\vdash	Н	
Rehabilitation Techniques						•								

Need	Date	Γ,	/isit	. 4	Date	\ \	/isit	2	Date		/isit	<u> </u>	<u> </u>
1660	Date	┟╌	P	<u> </u>	Date	H	P	6	Date	는`	P	Ö	Signature
Nutritional Guidance	 	一	Ť	Ť				$\dot{\vdash}$		<u> </u>	Ė		Dietician
	+	\vdash	_	\vdash				\vdash				H	10
Diet Instruction for patients at Nutritional risk		B	۰	2		U	ھد	9		P	8~		laria Cal
Diet advice for home	 			_		_	_			٦	8		Nurse
Discharge Planning	1											H	- 4025
Self care			╁╴	\vdash			-			┢─		Н	
Follow up	<u> </u>			\Box								П	
Reporting Concerns Immunizations													
Parenting education	 	┢	\vdash	H			_	Н	_		Н	H	
Others	+	┢	┥	┨		Н	_	Н		_	\vdash	H	
Risk Factor Reduction	+	┢	\vdash	 						-	┝	H	
Smoking Cessation	+-				,	.1			•	-		H	Doctor
Weight Control	+	┢	\vdash	H				•				H	
Exercise	+		\vdash	T				\neg	_			H	
─────────────────────────────────────	+	 										H	
Other Risks			┞	Н	-			Н				H	-
OUTCOME (O) - RD - Return Demons	, D- Deme	ons	trati	ion,		itten					(`		
OUTCOME (O) - RD - Return Demons	, D- Deme	ons	trati	ion,	W- Wri	itten							
OUTCOME (O) - RD - Return Demons Written Material given and explained	, D- Deme	ons	trati	ion,	W- Wri	itten							e Relationsh
OUTCOME (O) - RD - Return Demons Written Material given and explained	, D- Deme	ons	trati	ion,	W- Wri	itten							
OUTCOME (O) - RD - Return Demons Written Material given and explained Reports Given : Given Pendi	, D- Dem	ons	trati	ion,	W- Wri	ders						ndin	
OUTCOME (O) - RD - Return Demons Written Material given and explained Reports Given : Given Pendi Discharge Summary	, D- Dem	ons V - \	trati	ion, paliz	W- Writed Und	ders	tanc						
OUTCOME (O) - RD - Return Demons Written Material given and explained Reports Given : Given Pendi Discharge Summary	, D- Dem	ons V - \	trati	Diet	W- Writed Und	port	tanc						
OUTCOME (O) - RD - Return Demons Written Material given and explained Reports Given : Given Pendi Discharge Summary	, D- Dem	ons V - \	trati	Diet	W- Writed Und	port	tanc						
OUTCOME (O) - RD - Return Demons Written Material given and explained Reports Given : Given Pendi Discharge Summary ECG Report Doppler Report	, D- Dem	ons V - \	trati	Diet	W- Writed Und	port	tanc						
Discharge Summary	, D- Dem	ons V - \	trati	Diet CT S	Advice Scan Fil	port	tanc		Giver				
OUTCOME (O) - RD - Return Demons Written Material given and explained Reports Given : Given Pendi Discharge Summary	, D- Dem	ons V - \	trati	Diet CT S CT S ECH	Advice Scan Re Scan Fil	port m	ort						

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Mrs.UMA P

56/Female/MHJ202381495 10/01/2024/IPH2024000083

Dr.G. GNANAVELU





Inter Disciplinary Team Rounds (IDTR) Checklist

Date: 10/1/84.	Time:	110	QO			
Checklist	Yes	No	NA	Ac	ction / Remarks	
MEDICAL		·			è	
Daily Consultant Visit					-	
Plan of care discussed						
Discharge Planning			}			
Others if any					-	
NURSING				· · · · · · · · · · · · · · · · · · ·	<u> </u>	
Safety Precautions Ensured			_			·
Care of Lines and Tubes .		<i>/</i> .				
Infection Control Measures						
Skin Care	/		ļ		<u></u>	
Response to assistance			ļ			
Others if any						,
DIETICIAN				* *	<u> </u>	
Diet Adequate	1		<u> </u>			
Special Request			_	,		
PHYSIOTHERAPIST						
Available for Assistance for Activities of Daily Living						
Others if any						
PATIENT CARE SERVICES						<u>.</u>
Room Cleaning satisfactory				·		
Room Amenities Adequate			<u> </u>			
Billing Update available						
Non-Availability of any service						
Spiritual Needs (if yes specify)						
Others if any						
		lr	iter Dis	sciplinary Team Members		
Doctor	Signatur	7		Name Dr. Anusoya	Reg. / Emp. No.	Date Time
Nursing Staff	(Par				134559	10/10/19/19
Dietician			<u> </u>	Illaria Catherine John		10/1/2/18/20
Physiotherapist				Senior Diethtan	John 1	10/11/13/10
Patient Care Service Staff					 	



Mrs.UMA P

56/Female/MHI202381495 10/01/2024/IPH2024000083

Dr.G. GNANAVELU





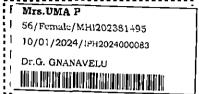
IN-HOUSE TRANSFER FORM

Part	A (to be filled by Nur	rses)												
Date	e of Transfer: [[//\วน	Time: _{6:	30 Tra	ansferred	from: CCC) ·To:	St Flany P-NO(11)							
Diag	gnosis: CAO	1mm ma	(moran)	יטוסו טוני	nlow l	1 PC17, UMO	tr ca							
Vital	Vital Signs: Temp: 48 (°F) Pulse / HR: 80 (beats/min) BP:116 69 (mmHg) Respiration: 30 (breaths/min)													
Part	B (to be filled by Phy	vsicians) p	Any Critic	al Investig	jations:									
<u></u>	Check for			Trai	nsferring Docto	or	Receiving Doctor							
lesp	iratory (Breath sounds)	Clear] Crepitat	ion 🔲 F	Rhonchi 🔲 O	thers:	Yes No							
Abdo	men	Soft	Tender		oistended O	thers:	Yes No							
Hear	t Sound	Normal [Feeble	Loud	d Others:_		Yes No							
CNS	· -	Consciou	ıs 🗌 Or	iented	GCS Sco	re:	Yes No							
	urgical Patients	Surgical Site:	Heal	thy S	oakage 0	thers:	Yes No							
	<u> </u>	Prese	nt Medic	ation (for	Medication R	econciliation)	•							
S. No.	Current Medic	ation	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay							
١	F: WROARNE		200mg	Pro	1-0-1	14/124@ 9:50	. ∠́ Yes ☐ No							
م	Cop. Uzbanggin	J	15~~	81-	0-0-1		☐ Yes ☐ No							
3	7. REMMAZ		4004	β.,	(-0-1	11,1240 9.80	☑'Yes □ No							
	7. Ferens - B		O	10.	1-0-7	11/124 @ 8:30	☑ Yes ☐ No							
3,7	7. CREVAST		لارعم	1.	0-07	10/1/24 @ 20:00	☑'Yes ☐ No ,							
Ь	9-12052		904	V •	1-2-1	11/124 08-30	່ ⊈Î Yes ⊟ No							
٦	7. EWSPRIN		75)	ρ,	0-1-0	11/1/24 DILIBO.	Yes 🗆 No							
8	7-pano40		42	1.	1-0-1	11/124 @8:30.	☐ Yes ☐ No							
9	7. CMON-CC	_		ρ.	0-0-1	10/1/24/021:00	☐ Yes ☐ No							
10	7. ntoros		75mg	P.	1-0-0	11/1/24 @8,30	☐ Yes ☐ No							
17.	7- CANBRIT		(Mys	V ~	1-0-0	11/1/24 68:30	∐ Yes □ No							
							☐ Yes ☐ No							
							☐ Yes ☐ No							
	·						☐ Yes ☐ No							
							🗌 Yes 🗌 No							

Additional De	tails (if any):		-		•
Patient Condi	4:	Stable	Siek need wreet and Oth			
Patient Condi	Sign		Sick-need urgent care Oth	ers:Reg. No.	Date	Time
Transferring Doctor	3igii		or wish	88434	. \ .	7 10 3°
Receiving Doctor		L.gh	Dr. Anusuya.	134559	ulila	' _
Part C (to be I	illed t	by Nurses)				
Check for			Transferring Nurse			eiving Nurse
Drains	_	Chest A	bdominal Others: Nil		🛂	Yes No
Respiratory		Air Way Type: Oxygen Therapy		s:li/m	in 🔽	Ŷes ☐ No
NG Tube / Oral		Yes No	For Feeding Gastric Suction	Fluid Restriction	Ø	Yes No
Foley's Catheter	r 	Yes No				Yes No
Intravenous Acc	ess	Peripheral Lir	ne Central Venous Line Others	S:	_ 7	Yes 🗌 No
Pressure Injury		☐ Yes ☐ No	If Yes, give details:		_ 🖯	Yes ☐ No
Score		Fall Risk: 50	WELLS: NEWS / PEWS:		Ţ Ţ	Yes No
Patient Belongir	ngs ———	Yes, No	If Yes, give details:		<u> </u>	Yes No
Handover Detail	s		inistration Record explained: Yes c Reports handed over Yes N	-		Ƴes ☐ No
Patient Attendar Informed	nt	□xes □ No	If No, give details:			Yes 🗌 🔻
Additional De	tails (i	if any):				
	Sign	·	Name	Emp. No.	Date	Time
Transferring Nurse	ξ.	lette.	& fuernal utra	0 上//	મીતીત્રમ	10.30.
Receiving Nurse	(July .	& fuemalatha B Vanish	0/190	ulday	10,30









FAMILY COUNSELLING FORM

CONSUI	TANT-DP.	CIMANAVE	DIAGNOSIS- PODM DYSLIPE	=DIMIA /	NO 210	D _
DATE	HOSPITAL MEMBERS	FAMILY MEMBERS	MEDICAL UPDATE	FINANCIAL UPDATE	PATIENT REP-SIGN	DOCTOR SIGN
60/1/64	A POP		A Conditues apolled to		4.74.	91310
ulılər	Doctor.		Pr. Wording Oxpunans 10 Mms	_	Br	pul







REQUISITION MIS.UMA P

(A Unit of United Alliance Healthcare Pvt Ltd)

56/Female/MH1202381495

Name of Patie

10/01/2024/IPH2024000083

Age / Sex

Dr.G. GNANAVELU

Consultant Nam

IP No. DOA UHID No.:

Room No.: ([U:

S.No.	Date	Medicine Name	Qty.				
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<u>דין</u>	71	7. 100011 - 1 1 10h	<u></u>				
ly	11	T. Reminery Junomy	5				









Where heart beat nover stops...

REQUISITION FOR MEDICINE

(A Unit of United Alliance Healthcare Pvt Ltd)

IP No.

Name of Patient

HRS. Uma . P

DOA

Age / Sex

UHID No.:

Consultant Name: Room No.:

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		<u> </u>
		
77		
		11 by The Control of the State

Nurse Name

Pharm Bill & Name







Every heart beat counts

VIP SCALE (VISUAL INFUSION PHLEBITIS)

Mrs.UMA P

PATIENT NAM 56/Fcmalc/MHI202381+95

10/01/2024/!PH2024000083

AGE / SEX:

Dr.G. GNANAVELU

IP No. / UHID No

Ward / Bed No. []

ANY SCORE-O SHOULD BE MONITORED IN EVERY SHIFT

		ANT	3CORE>	O SHOULD BE MONI	TORED IN E	VERT OIM I	
DATE	TIME	SITE	SCORE	DESCRIPTION	ACTION	FOLLOW UP	S/N EMP No.
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	2/60	Gradial	013	potent	Flux had	Followed Followed	Bony
	8.00		015	Patent	Flushool	Followed	8 20
1/1/24.	14:00	Phrachial	ols	Patent	Hushed	· •	Hayolos
		Pt high		Patent.	flushed		Ter.
l 				ad line	Remov	ed	







Mrs.UMA

56/Female/MHI202381+95 10/01/2024/IPH2024000083

Dr.G. GNANAVELU



ALLERGY

Heart

25 - 2

1M/2022/028

Every heart beat counts

MEDICATION ADMINISTRATION RECORD

Dru	g Chart	of	<u>-</u>		Heig	ht (cms):	166 cm	Weigh	t (kg):	Ky			
		KNOWN MEDICINE AI	LERGIE	S (if NO	ONE is c	onfirmed	, write NKDA i	n box 1)		_			
Drug D	etails		Descri	ption of a	Allergy				or's Sign:				
							•		(D)	_ !			
1	T	DEDIFF.		٠, ٠			•	, Nam	e: 24-11/2/10	inied)			
	Z	, you Allergy.	ļ		-		N .	Reg.	No higher	۲)			
			<u> </u>			1	<u>.</u>		1673	<u>ഗ</u>			
	осто	RINSTRUCTIONS	NURSING STAFF INSTRUCTIONS 1. Check entries in every section to avoid omissions										
_		me when prescribing drug LETTERS, clearly and legibly	2. Nurse in-charge should verify drug chart on daily basis 3. For new prescription, follow the timings of doctor's prescription on Day 1 only, and then										
		MCI registration no. or apply seal	follow	standard	timings	_	·	-	•				
-		should be altered / overwritten					112hrly: 10:00hrs, 22 9:00hrs, 14:00hrs, 2			rs,			
5. USB 2	4-11007 107	mat when writing time					00hrs, 06:00hrs, 10:	:00hrs, 14:0	00hrs, 18:00hrs,	22:00hrs			
		Stat / C	Once O	nly / P	remed	ication	Drugs	<u> </u>		'. 			
Date	Time	Drug		Dose	Route	. '	Doctor		Administered	<u> </u>			
		<u> </u>	_			Sign.	Reg. No.	Sign.	Emp. No.	Time			
101,124		INJ: FENTANYL	<u>, 🕸</u>	25 mg	σV	(4	loaybb		0160016	14.40			
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D/ De	14-40	&NJ: HEPARIN	匁	2000	1A	h	102466		0/00/6	14,40			
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To be filled by Nursing Staff only. Sign and time given Date → REGULAR PRESCRIPTIONS To be filled in by Doctors only Time v **DRUG NAME** Clinical Pharmacist Medway Heart Institute 7. Calbrit Route 8:00 Dose Frequency Itab too, Start Date & Time Dr. Sign & Reg. No. / Seal 01124 for 165 mg Stop Date & Time Additional Info: DRUG NAME T. Thyrox Clinical Pharmacist Medway Heart Institute Dose Route Frequency P.00 15mca Dr. Sign & Reg. No. / Seal Start Date & Time 10/1/24 Stop Date & Time BO 16582 Of Additional Info: 830 **DRUG NAME** T. Ranozex 8:00 0 Clinical Pharmacist Route Frequency Zasmi Dr. Sign & Reg. No. / Seal Start Date & Time 00:00 Stop Date & Time Co uson Ø 11/102-00 9 130 Additional Info: **DRUG NAME** T. Evion LC Clinical Pharmacist Medway Heart Institute Route Dose Frequency Lab 0-0-1 201.00 20.3 2000 Start Date & Time Dr. Sign & Reg. No. / Seal 10 11 24. Too usm *യ* Stop Date & Time Additional Info: DRUG NAME T. Pantocid 4.00 Route Clinical Pharmacist Medway Heart Institute Frequency Dose. Start Date & Time Dr. Sign & Reg. No. / Seal 19:00 Box 112m Stop Date & Time Additional Info: Area In-charge **Nurse Signature:**

		ı								<u>.</u>		
ľ	REGUI	LAR PRESCRIF	PTIONS I	Date →	To be	filled b	y Nurs	ing Sta	ff only.	Sign at	nd time	given
ļ		filled in by Doctor		Time ↓	Pip	1/1/10	19/1/2	<u> </u>				
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acist titute	Dose 70-1	Route	Frequency	14,00	5	13.40	14:00		• 			
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[Additional Info:				<u> </u>		<u> </u>	ļ				
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d	(D 1022	Stop Date & Time									
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			Stop bate a Time									
	Additional Info:			•		•	/					
1	Area In-charge Nurse Signature	:	`		16	fo	ارمو موليا	k	ļ	, -		

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Area In-charç Nurse Signat			·	W.	19/						

7 `AO DEG	-	DIDTIONS	Date →	To be	filled b	y Nurs	ing Sta	iff only.	Sign a	nd time	given
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Additional Info:									 -		
Area In-charge Nurse Signature			·				:		_		

3

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_		Intravenous		Rate /		Additive Drug						Adr	ninistratio	n
Date	Time	Fluid	Volume	Duration	Route	Name	•	Dose	Range	Sign.	Reg. No.	Start Time	End Time	Sig
1189	14-30	GVP:NS	500ml	30ml/hr	W	0-9-1.	NS			N	(subb	14.30	10/1/24 23:00	010
	1													
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		<u> </u>												<u> </u>
				<u> </u>										
	-					 -								
											-			
													-	<u>`</u>

PARENTERAL INFUSION PRESCRIPTION AND ADMINISTRATION RECORD **Additive Drug** Doctor Administration Rate / Intravenous Volume Date Time Duration Fluid Dose Sign. | Reg. No. | Start Time | End Time | Sign. Route Name Range

Date	Time	Diet	Signature	Reg. No.	Date	Time	Diet	Signature	Reg. No.
<u> </u>			-/-/-		_				
ملالعع	17:30	Dm diet	W	91310					
•	8:00	DM Diet	Duly	88439.				·	
1211/24		Diabetic dielr	N-80	13455	ñ		i		
_		,							
					•				

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			
poliby	Evening	Rathern prings	10/84	B 5		Evening			
0/1/2	Night	Marthumitha	O2AH	k.	٠.	Night			
11/124	Morning	& Puemalatha	0271	20		Morning		_	
بلاليا	Evening	H. Rovalli	0225	MA	<u></u>	Evening			
عبدأيل	Night	Seripoye.	0284	Jon ,		Night			
علىك	Morning	* []	2375	₩.		Morning	<u> </u>		
12/1/20	Evening	Hannah Grace				Evening			
\	Night					Night	7 -		
	Morning					Morning		47)	
	Evening					Evening	51		Á
	Night					Night (8 . •	/





Mrs.UMA P 56/Female/MHI202381+95 10/01/2024/IPH2024000083 Dr.G. GNANAVELU



INTERMEDIATE CARE FLOWCHART

A

NAME: MORS. UMA P

UHID NO このの名りなるGE:56V

SEX:

SURGICAL PROCEDURE: PTCA +0 LAD + PCA + IVUD

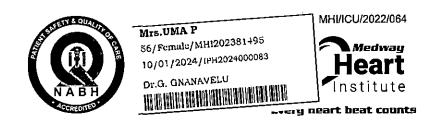
POSTOP DAY: 1,1

FLUID REQUIREMENT:

URINE I.V. FLUIDS ORAL/ R.T. **CHEST DRAINAGE** DATE TOTAL TOTAL TOTAL INTEKE BALANCE TOTAL & TIME **OUTPUT** G.T. H.T. G.T. н.т. H.T. G.T. H.T. LEAK 8.00 fg) 50 50 **50** 150 good doo *(***)**200/(**)** aos don goo gov 1000 SPECIFIC OBSERVATIONS/REMARKS **MEDICATION / DRUGS**

Asis: - 720m) CAJCIFIC LAD & REA DISEASE \ (1) IN FUNCTION |





INTERMEDIATE CARE FLOWCHART

A

NAME: HOS. UMA

UHID NO: 20238149, TAGE: 564

SEX : 🧲

SURGICAL PROCEDURE: PTCH TO LAD TREA + IVUS

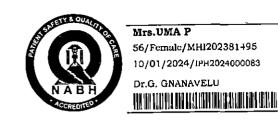
POSTOP DAY: \mathfrak{D}_1

FLUID REQUIREMENT:

DATE	URINE		, 		TOTAL		I.V. FLU	ID\$	ORA	L/ R.T. TOTAL		TOTAL		
& TIME	н.т.	G.T.		AIR LEAK	H.T.	G.T.	ОИТРИТ	Ms		н.т.	н.т.	G.T. ሮዓ ላ ታ	INTEKE	BALANCI
4:00		300					300	30		30		220	580	728c
18:10		300					300	30		30	120	670	700	the
19:00		1200					1200	80		30	20	bgo	<u>420</u>	450
Do D		1200			-		1200	30		30	50	740	830	340
21.00	_	1200					1200	30		30	150	890	1010	190
22.00		1200					1200	30		30	50	940	0P01	110
2300	400	1600					1600	30		30	50	990	1140	H/30
_O 09		1900					1600	plc				990	סדנו	- H30
1.00		1600	•	ı			1600				50	10110	1220	380
2,00		1600					1600					1010	1220	380
360		1600					1600					1040	1220	- 380
% €00	300	0091					1900				50	1090	1270	630
F60	ĺ	P00					1900					1090	1240	- 630
5.00		1900					1900					1090	1240	ļ
1.00		1900					1900				50	1140	1320	580
SPEC	IFIC O	BSERVAT	rions/f	REMAR	KS			MEDI	CATION / E	RUGS				
						,								

R.NO:111.





MHI/ICU/2022/064

Medway
Heart
Institute

INTERMEDIATE CARE FLOWCHART

В

NAME: MORS ONDA P

UHID NO: 200981495AGE: 564

SEX: F-

BLOOD GROUP:

HEIGHT #186 CM

WEIGHT # 1 kg

B.S.A: 1.28 M

HAEMODYNAMICS						RESI	P. PARAMET	INVESTIGATIONS /						
TEMP	H.R.	RHY.	ST.	B.P.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2			HER DATA	
8:00	84	ring	98F		.\ 6 5	mann	H	17	Brlo	વૃક્ષ	Pt	ρn	600M	WE.
		Saring S	98'F	133	96	meur	1++	16	Bylel	99		p	<u>.</u> .–.	
		givu	186		98	Monay	44	18	BILL	1001		′,		
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	-													
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					_						_			* *
	_										_			
			_						REVIOUS DAY			_		

DRAINAGE

URINE => 1900 ml

TOTAL INTAKE => 13 20 m

TOTAL OUTPUT = > 1900 m

BALANCE = 3 580 m





Mrs.UMA P 56/Female/MHI202381495 10/01/2024/1РН2024000083 Dr.G. GNANAVELU



Every heart beat counts

INTERMEDIATE CARE FLOWCHART

В

NAME: HOLLUMA

UHID NO: 202 381495 AGE: 564

SEX:

BLOOD GROUP:

HEIGHT: 466 CM

WEIGHT: 7 1 109

B.S.A: 1.28 m.

	HAEMODYNAMICS							RES	P. PARAMET	TERS_	INVESTIGATIONS /
TEMP	H.R.	RHY.	ST.	В.Р.	R.A.P.	PERI.	P.P.	RR	BREATH	SPO2	OTHER DATA
14:00	189	C) (NIX)	asip	194		SOCIOTAL		3	Bla	994	ON RA
18:00		Simb	984	141		maken		80	Bych	28:1	vf
19:00				130	99	BARR	ar.	18	exict	997	н
2000		Sinus	91.2	153		Wg/M		15	131d °	98%	n
21.00	85	-5; n g	(1.2)	'		_{ઈ.} વનજ		16	Bld	98%	! 1
22:00	80	5ms	94.32	367	90	anoth,	τ [*]	2)	Nd	97%	n ·
23.00	1		94.2	122 Toh	,	200		20	rsld	981	у
D0 ಹಾ	92				93	wgrw	4	23	Bld	91%	h
୍ତେ	93	ins	942	117	834	Mpc	4+	20	13/10	98%	1)
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400	60	siry.	机之	129	33	modal	A	22	·Bld	97%	I ₁
500	80	[ر عام 1.5	142		rosen		2A	139 d	82:	η
6,00	bo	Sins	q4,2	129	33·	20hr	オ	رَ2	Brd	974	1) , .
ಪ್ರಾ	88				ko 1	waym		1,8	Brd	99,4	11.
					,						·
							,	PI	REVIOUS DAY	r - HOUR	s
1	DRAINAGE TOTAL INTAKE										

URINE

TOTAL OUTPUT

BALANCE



MRD CHECKLIST

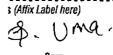
PARTICULARS	YES	NO
- IP Number allocated to each Patient		
- Name, Age & Sex of Patient		
- General Admission Consent	/	
- Initial Assessment of Patient / Diagnosis	(
- Nutritional Assessment by Consultant		
- Plan of care counter signed by the Consultant	/	
- Treatment Orders - Date, Time, Name & Sign.		
- Medication Order / Drug Chart - Date, Time, Name & Sign.	(
- Vital Signs Chart (TPR Chart)	(-
- Intake Output Chart	(<u></u>
- 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		



Mrs.UMA P

56/Female/MHI202381495 26/12/2023/IPH2023002598

Dr.G. GNANAVELU







consultant:

Every heart beat counts

Medway Hospitals

(A Unit of United Alliance Healthcare Pvt Ltd)	ADMISSION SLIP	2 G
Admitting Doctor: & Granavelu	Speciality: Coulce	logist-
Advised Date & Time: 8 6 2 2 3		
Provisional Diagnosis:		
DLP		
Reason for Admission: Medical Manag	ement Surgical Management	
Others (please	specify details)	
Admission Type: Day Care	☐ ER ☐ Ward	
☐ icu	(Specify details)	
Surgery / Procedure Name (if planned):		
CAG		
	s (Kindly specify details of components required in	
. /		,
Expected Duration of Stay:	Care	
Expected Cost of Treatment (as per Financial C	ounseling Form):	
Payer: Self Insurance Others:	,	\ ₁
		1, 1
Instructions to Nurse (if any): Adruk in	ERL	
Any other Instructions (if any)		
Any other Instructions (if any):		
Doctor's Signature Name	Reg. No.	Date Time

For admission desk staff only:								
Room Category:	General Ward Single Room Twin Sharing Deluxe Room Suite Room Others	_	,					
Admission intimation	on Receipt Details	Admission Ti	me in HIS					
Date	Time	Date	Time					
26/12/23	1).0500	26/12/23	11. DSay					
Source: OPD ER Direct To be filled only if Blood requirement specified by the Doctor: Is Blood Reservation and Blood Bank clearance completed as advised: Yes No								
Front office Staff Signatur	e Name Jean Blay	Emp. No. MH/1273	Date 11/1 Time 11/152					
		-						

Medway Hospitals

MH-CMA-P Patient Details (Affix Label here) Name: My 202 381495

DOB: 1982 2002 \$ UHID: DOA: 26 12

Medway

MHI/HOSP/2022/129

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

ADMISSION FORM

		7.51111						
Marital Statu	ıs Full Add	tress or Radh	elevishon raa-		Telephone Number			
Occupation		Hiraran			7917-628485			
Referred from	m ,		Date & Time of Discharge		No. of Days			
Dr. Chana	wetter	26/12/2023 11:05.	26/12/2) at	JM				
UNIT	RL.	MLC Yes	No If Yes AR	No.:				
	•	FINAL DIAGNO	sis		ICD Code			
BIFASCICULAR BLOCK								
		Iso. <u>9</u>						
	TYPE	- II DIABETES I	mELL ITU]		E11.9			
	H	LPO THYRO/DISM			F03.9			
		E185						
	راک	NUS RHYTH.	m		J49.8			
DATE		OPERATION /	PROCEDURES		ICPM Code			
36/12/23	CO 1	RONARY AND	log ram		B&-50			
DATE		TYPE OF A	NESTHESIA					
26/12/2)	☐ GENERA	L SPINAL	LOCAL [] REGIONAL	EPIDURAL			
		DISC	CHARGE STATUS					
☐ Cured		☐ Discharge at Req		_ E>	pired < 48 hours			
□ Improve	ed	☐ Against Medical A	Advice	□ Ex	pired > 48 hours			
☐ Unchan	ged	□ Absconded □ Transferred to		□ Po	ost-Operative Death			
Signature	Signature of the Consultant (B Signature of Medical Records Officer							
		- ()			S.No. : 5			

AUTHORISATION FOR TREATMENT I PAYMENT

I hereby authorise the Administration, Medical administer such drugs as may be necessary a deemed necessary and / or advisable in the dwho is my	and to perform such operation iagnosis and treatment of m	on under anaesthesia or other wise as	may be -
I hereby under take to settle all the bills for hob basis. In any case, I shall pay all the dues befo	· ·	•	a periodic
However, in case I fail to pay the charges due me/the patient to any other hospital/institution		-	
I also acknowledge having been informed if the and valuables belonging to the patient or theis next of kin and I absolve the hospital of any re	s attendants have been rem	oved to a place of safety / handed over	-
I have read out and explained the contents of	the above to the Signatory i	n his vernacular .	
சிகீச்சை, பணம் செலுத்துதல் முதலியவை செய்ய			
இதன் மூலமாக நான் நிர்வாகம், மருத்துவம், தாதிய மருந்துகள் கொடுத்து செய்முறைகள்/அறுவை சிக் செலவுக்கன தொகை முமுவதும் செலுத்த இதன் மூ	க்கு தேவைப்பட்ட சோதனை இச்சை செய்யவும் அதிகாரம் வ	னகளை செய்து மருந்துகளை கொடுக்க	வும். மயக்க
மேல் கூறியது போல் வேளை நான் தங்கள் மரு மருத்துவமனைக்கு, பிற சிகிச்சை / அறுவை சிகிச்சு அளிக்கிறேன்.			• -
மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி	தெரிவிக்கிப்பட்டிருக்கிறேன்.		
நோயாளிக்கு உரிமையான எல்லா பணம், நகை ம நெருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ளது. இ என உறுதி செய்கிறேன்.			
மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்	ட பிறகுதான் கையொப்பமிட்டே	டன்.	
	26/12/2017.	wer	•••
െങ്ങി യിயர் കെഡെന് വയ [്]	தேதி	எனது/உறவினர்/காப்பாளர் கையொப்	பம்
Signature of Admitting Nurse	Date	Signature of the Patient / Relative	/ Gurdian
		Uma	•

உறவுமுறை

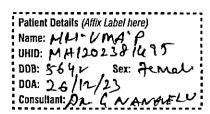
Nature of Relationship



discharge.









GENERAL CONSENT FOR ADMISSION

i		the Patient or	☐ Representative of patient have
(pi	lease tick the correct option above and below)	_	_ ,
] Read		
	Been explained this consent form in English, which	I fully understand.	
•	I give my full consent and authorization for admissi plan has been explained to me.	ion and treatment at thi	s hospital. The proposed treatment
•	I consent and authorize the hospital, treating doc relevant care and to conduct diagnostic as deemed		
•	I also consent to use of assistants such as resident d by the hospital and treating doctor/ team.	octors, other doctors, n	urses, and other healthcare workers
•	I consent for clinical consultation, admission, disclost confidence), routine medical examination (physical lab and imaging investigations, general nursing care	l examination, palpatior	n, percussion, auscultation), routine
•	I have been explained about the proposed care placest of treatment/ hospital stay.	an, expected result(s),	possible outcome(s) and expected
•	I understand that the hospital will take due care of unexpected complication(s) which may necessitate cases, procedure different from those contemplated	longer stay and / or us	e of intensive care services. In such
•	I declare that, I have and will inform the doctor of my reaction(s), surgical procedure, relevant medical fa shall not hold the hospital/ doctor responsible for an relevant information on my part.	amily history and all oth	ner facts relevant to my treatment. I
•	I declare that I have been explained about my rights	s and responsibilities.	
•	I have been made aware of the rules and regulatio promise to abide by them.	ns of the hospital inclu	ding those related to security and I

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.

	Signature / Thumb Impression*	Name	Date	Time
Patient	Um	uma	26/12/25	11.05
Surrogate/Guardian (if applicable #)	July	(Write name and relationship with patient)	26/12/2	Hier
Reason for surrogate consent	Patient is unable to give consent	because:	_	
Witness				
Interpreter (if applicable)				

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







DAY CARE DISCHARGE SUMMARY

IP No.

IPH2023002598

D.O.A

: 26/12/2023

UHID

MHI202381495

D.O.P

÷ 26/12/2023

Name

Mrs. UMA, P

Room No. : RL

Age / Gender

56 Years / FEMALE

Consultant - '

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

D.O.D

: 26/12/2023

Chief Cardiologist

DIAGNOSIS:

BIFASCICULAR BLOCK NORMAL LV FUNCTION TYPE II DIABETES MELLITUS **HYPOTHYROIDISM** DYSLIPIDEMIA SINUS RHYTHM

PROCEDURE: CORONARY ANGIOGRAM DONE ON 26.12.2023 - SIGNIFICANT CALCIFIC LAD & RCA DISEASE.

BRIEF HISTORY:

Mrs. Uma. P. 56 years old Female, Presented with complaints of chest pain. She was advised Coronary angiogram and referred to Medway Heart Institute on 26.12.2023 for which she has been admitted.

EXAMINATION:

HR: 84bpm;

BP: 150/90mmHg;

SPO₂: 99% in room air

CVS: S1S2+; RS:Clear;

CNS: NFND;

Abd: Soft

INVESTIGATIONS:

BLOOD(14.11.2023): Hb- 13.0gm/dl.

ECG: sinus rhythm, HR – 80bpm, complete RBBB, VPD

ECHO: Normal valves & chambers. No wall motion abnormality. Normal LV function. EF – 75%. Normal pulmonary artery pressures. Occasional ventricular ectopics.

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

★ @MedwayHospitals

@medwayhospitals

@medway-hospitals

@medwayhospitals

94457 94457 1800 572 3003

Medway Group of Hospitals

Medway Centre of Excellence (Chennai)



UHID: MHI202381495



Every heart beat counts

CORONARY ANGIOGRAM FINDINGS:

(A Unit of United Alliance Healthcare Pvt Ltd)

Right-dominant system; SIGNIFICANT CALCIFIC LAD & RCA DISEASE .(reports enclosed)

ADVICE: IVUS GUIDED PCI to LAD / RCA

ADVICE MEDICATIONS:

Sl.	NAME OF THE DRUGS WITH	DOSAGE	FRE	QUE	NCY	ROUTE	RELATION	DURATION
NO	GENERIC NAME		M	A	N		SHIP WITH FOOD	
1	TAB. ECOSPRIN	75MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. AXCER	90 MG	1	0	Ī	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. ROZAVEL	40 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB. THYROX	75 MCG	1	0	0	ORAL	EMPTY STOMACH	TO CONTINUE
5	TAB. RANOZEX	500 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
6	TAB. CALBRIT	1 TAB	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
7	TAB. EVION LC	1 TAB	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
8	TAB. PANTOCID	40 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
9	TAB. TRIVOLIB	1 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
10	TAB. STALIX	50 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
11	TAB. FOURTS B	1 TAB	1	0	0	ORAL	AFTER FOOD	TO CONTINUE

DISCHARGE ADVICE						
DIET	LOW FAT & DIABETIC DIET.	·-				
PHYSICAL ACTIVITIES	AVOID STRENUOUS ACTIVITIES.					
REVIEW	REVIEW WITH DR. G. GNANAVELU FOR PCI.					

To report:

@MedwayHospitals

044-2473 4455

If temp > 101 'F / Difficulty in breathing / chest pain / Giddiness/ palpitations.

In case of emergency Contact: Medway Hospitals @ 4310 8959.

Dr. G. Gnanavalu MD, DM (cordio), FACC Chief Cardiologist

Reg. No: 39469

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

"Under Stood the Content of the Co

Kodambakkam, Chennai - 600024. Tel: 044 - 4310 8959

(O) @medwayhospitals

medway-hospitals

@medwayhospitals

94457 94457 1800 572 3003

Medway Group of Hospitals Kodambakkam Mogappair Kumbakonam

Chengalpattu 044-26530011 | 044-2473 4455 | 044-27426829

Villupuram 04146-242000

Heart Institute 044 - 4310 8959

Medway Centre of Excellence (Chennai)

Institute of Pulmonology 044-2473 4454

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

MHI/HOSP/2022/118





MIS.UMA P

56/Female/MHI202381+95 26/12/2023/tPH2023002598

Dr.G. GNANAVELU





DAY CARE INITIAL ASSESSMENT FORM

Date: 26 12 23 Time of arrival: 11.30 Part A (to be filled by Nurses) Any Language Barrier: ☐ Yes ☐ No If yes, please call Language Coordinator / Translator Allergies (Yes | No If Yes, specify: SULDHA DRING Psychosocial Assessment: Alcohol Intake: ☐ Yes ☐ No Substance Abuse: ☐ Yes ☑ No Smoking: ☐ Yes ☑ No Do you have any special religious, spiritual or cultural needs to be considered?

Yes Aro If Yes, specify details: Pain Screening Pain: Yes No. If Yes, Score: Pain Scale used: PIPPS (28 weeks to < 38 weeks) CRIES (38 weeks - 2 months) FLACC Scale (2 months - 7 years) Wong-Baker FACES Pain Rating Scale (7 years - 12 years) Numerical Rating Scale (Age more than 12 years) _____Location: Pain Character: Dull Aching Sharp Stabbing Shooting Burning Referred / Radiant Pain Nutritional Screening: Last 3 months Appetite ☐ Increased ☐ Decreased ☐ No Change Last 3 months Weight ☐ Increased ☐ Decreased ☐ No Change Fall Risk Screening for adults: No Risk ☐ Age more than 65 years ☐ History of fall in last 3 months ☐ Walks with assistance ☐ Any neurological problem In case of 2 or more criteria met.initiate detailed fall assessment and fall prevention protocol Fall Risk Screening (for pediatrics), ☐ H/O fall in last 3 months ☐ Neurological problem (vertigo, seizure, etc) ☐ Deranged Mobility ✔ No Risk In case of 2 or more criteria met initiate detailed fall assessment and fall prevention protocol Signature Emp. No. 26/30/23 11.35 022 Nurse " M. Revoth

			ar r	,		
Pai	rt B (to be filled by Physician	s)				
Chi	ef Complaints					
	•	cto o	f co	hert poer	(h	
Pas	t Medical History		, T			e de la companya de l
		_				·
		٠.				**************************************
Pe	rsonal History					
	nificant Family History				,	e Marija je je
Cur	rent Medication					and the second s
S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during bespital stay
	TAB. ECOSPRIN	Fory	Po	0-1-0	27/12/23 et 2pm	∐Yes □ No
	TAS. AXCER	9014	po	1-0-1	26/12/22 at 8AM	Yes□No
	JAR . ROZAVEL	Long	٥٥	0-0-1	25/12/21 of sym	☐Yes☐No
	TAB. THYROX	Frace	ps	1-00	26/12/23 of 6 pm	☐Yes☐No
	TAB. RAPROZEY	Sory	po	1-0-1	20/12/23 stran	Ú Yes □ No
	TAB. CALBETT	(TAB	Po	1000	26/12/23 of sa	∐ Yes □ No
	TAB. EVIDA LC	ITAB	Po	0-0-1	25/14/25 atom	☑ Yes □ No
	TAB. PANTOZIA	hom	plo	1-0-1	26/12/25 of Jum	∐ Yes □ No
	MAR. TRIVOLIB	lmh	PW.	(~~~~ <u>\</u>	26/12/22 at gam	☑ Yes □ No
	TAB. STALLX	60m	plo	1-0-4	26/12/23 4850	☑ Yes □ No
	PAR. POURTED	[TPB	ofg	500	26/12hsatter	To.

Clinical Examination / Investigation

Hb= 13.0gm/dl.

Provisional Diagnosis

BIFASCICULAR BLOCK
NORMAL LV FUNCTION
TYPE II DIABETES MELLITUS
IN YPOTHYROIDISM
PYSLIPIDEMIA
SINUS RHYTHM

Plan of Care (including Investigations Ordered)

CAG

Doctor's Signature

Name 19 Coufully by

Reg. No. 85851

Date 26/14

Time 11.450





Mrs.UMA P 56/Female/MHI202381+95

26/12/2023/IPH2023002598

Dr.G. GNANAVELU



heart beat counts **DOCTOR'S PROGRESS NOTES** DATE **NOTES** Mr. Moto 26/W13 1 324 66 (U.Sa 00 254 _ り∨b 1- PTCA DLAD & RCA. plan dischaye +day 16.00







Every heart beat counts

Patient Details (Affix Label here)
Name: Mrs. Uma
UHID: MH 2023814195
DOB: 564 Sex: F
DOA: 26/12/23.
Consultant: Mr. Gnanguelle.

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

ious Beliefs:		72 Vegetarian	Non Vegeta	rian	Eggetarian	☐ Jain
Prescription	1600 (calones, L	Dulfat		biabetic d	, ō 0-
JECTIV	E GLOBA	AL ASSESSMENT		CONTRACTOR OF		
	(A) -	Patient's related Medical Histo	<u> </u>			
	1)	Weight Change (overall change	e in past 6 months)			
			TORING TORING	□3	, D4 5 ()	□ 5
ı	•	No weight change/	<5%	5-10%	10-15%	>15%
2)	Dietary Intake	Ouration:		J. N. " 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		
-1	l cary mane		D 2	<u> </u>		□ 5
	Oral	No change	Sub-optimal '	Full liquid diet/	Hypo - caloric	Starvation
			solid diet	moderate 1 / / / overall decrease	liquid diet	
-	Enteral / Parenteral Nutrition	Adequate / Excessive	Sub - optimal	Inadequate	Typo-caloric feeds	Starvation
3)	Garanintertie	al Symptoms Duration:		<u> </u>		
	Gastroutesur	1	1028114	, D3 1 (n) 7		□ s
	_		Nausea	Vomiting/	Diarrhoea	severe anorexia
		No symptoms		moderate GI symptoms	r.	severe andrexia
4)	Functional Ca	spacity (Nutrition related functional imp			C	
		4				
1		[D1]		□3	□ 4	□ 5
		Nane /Improved	Difficulty with ambulation	Difficulty with in normal activity	Light activity	Bed / chair - ridden with no or little activity
<u>.</u>		Nane /Improved	Difficulty with ambulation	Difficulty with	Light activity	Bed / chair - ridden with no
5)	Co - morbidity	None fimproved (Disease and its relationship to nutrition	Difficulty with ambulation ambulation arequirements)	Difficulty with normal activity	Light activity	Bed / chair - ridden with no or little activity
s)	Co - morbidity	Nane /improved (Disease and its relationship to nutrition	Difficulty with ambulation () and ()	Difficulty with normal activity	Light activity	Bed / chair - ridden with no or little activity
5)	Co - merbidity	None fimproved (Disease and its relationship to nutrition	Difficulty with ambulation ambulation arequirements)	Difficulty with normal activity	Light activity	Bed / chair - ridden with no or little activity
5) B)	Co - morbidity Physical exam	Name /improved (Disease and its relationship to niutritio	Difficulty with ambulation on requirements)	Difficulty with normal activity 3 Moderate co-morbidity/ age	Ughs activity	Bed / chair - ridden with no or little activity 5 Very severe multiple co -
B)	Physical exam	Name /improved (Disease and its relationship to niutritio	Difficulty with ambulation in requirements)	Difficulty with normal activity 3 Moderate co-morbidity/ age	Ughs activity	Bed / chair - ridden with no or little activity 5 Very severe multiple to - morbidity
	Physical exam	Name /improved (Disease and its relationship to nivirito Healthy	Difficulty with ambulation on requirements)	Difficulty with normal activity 3 Moderate co-morbidity/ age	Ught activity Severe co- morb/dity	Bed / chair - ridden with no or little activity 5 Very severe multiple to - morbidity
B)	Physical exam	Name /improved (Disease and its relationship to nutrition 1 Healthy Inination I stores or loss of subcutaneous fat	Difficulty with ambulation on requirements) 2 Mild comorbidity	Difficulty with normal activity Moderate comorbidity/ age >75 years	Ughi activity	Bed / chair - ridden with no or little activity 5 Very severe multiple co-morbidity
B)	Physical exam	None /improved (Disease and its relationship to nivirition 1 Healthy Inhaltion Istores or loss of subcutaneous fat.	Difficulty with ambulation and ambulation in requirements)	Difficulty with normal activity 3 Moderate comorbidity/ age >75 years	Ughi activity	Bed / chair - ridden with no or little activity 5 Very severe multiple co-morbidity
B)	Physical exam	Name /improved (Disease and its relationship to nutrition 1 Healthy nination 1 stores or loss of subcutaneous fat Normal	Difficulty with ambulation and ambulation and ambulation arequirements) 2 Mild comorbidity 2 Mild Mild	Difficulty with normal activity 3 Moderate co-morbidity/ age >75 years 3 Moderate	Ughł activity d severe comorbidity	Bed / chair - ridden with no or little activity 5 Vary severe multiple co-morbidity 5 Severe
B)	Physical exam	None /improved (Disease and its relationship to nutrition 1 Healthy Inflation Istores or loss of subcutaneous fat Normal wasting	Difficulty with ambulation () and () ambulation () and ()	Difficulty with normal activity normal activity Moderate comorbidity/ age >75 years Moderate	Ughs activity	Bed / chair - ridden with no or little activity 5
B) 1)	Physical exam Decreased fail	Name Improved (Disease and its relationship to nutrition 1 Healthy nination stores or loss of subcutaneous fat Normal Normal	Difficulty with ambulation and ambulation and ambulation arequirements) 2 Mild comorbidity 2 Mild Mild	Difficulty with normal activity 3 Moderate co-morbidity/ age >75 years 3 Moderate	Ughs activity Severe comorbidity	Bed / chair - ridden with no or little activity 5 Vary severe multiple co-morbidity 5 Severe
B) 1)	Physical exam	None /improved (Disease and its relationship to nutrition of the control of the	Difficulty with ambulation In requirements) 2	Difficulty with normal activity normal activity Moderate comorbidity/ age >75 years Moderate	Ughs activity	Bed / chair- ridden with no or tittle activity 5 Very severe multiple co- morbidity 5 Severe Severe
1) 2) 2) Total Score =	Physical exam Decreased fai Sign of muscle i	Name Improved (Disease and its relationship to nivirito 1 Healthy Innation Instores or loss of subcutaneous fat Normal Normal Normal	Difficulty with ambulation () and () ambulation () and ()	Difficulty with normal activity normal activity Moderate comorbidity/ age >75 years Moderate	Ughs activity Severe comorbidity	Bed / chair - ridden with no or little activity 5
1) 2) 2) Total Score =	Physical exam Decreased fai Sign of muscle Sum I above 7 com	Name /improved (Disease and its relationship to nivirition in the control of the	Difficulty with ambulation In requirements) 2	Difficulty with normal activity Moderate comorbidity age >75 years 3 Moderate :	Ughs activity Severe comorbidity	Bed / chair- ridden with no or tittle activity 5 Very severe multiple co- morbidity 5 Severe Severe
1) 2) 2) Total Score =	Physical exam Decreased fai Sign of muscle Sum I above 7 com Status: Based on this	Name /improved (Disease and its relationship to nivirition in the control of the	Difficulty with ambulation In requirements) 2 Mild comorbidity 2 Mild 2	Difficulty with normal activity 3	Ught activity	Bed / chair- ridden with no or tittle activity 5 Very severe multiple co- morbidity 5 Severe Severe
1) 2) 2) Total Score =	Physical exam Decreased fai Sign of muscle i Sum I above 7 com Status : Based on this Well Nourished Moderately Ma	Name /improved (Disease and its relationship to nivirition in the interest of	Difficulty with ambulation In requirements 2 Mild comorbidity 2 Mild 2 Mild	Difficulty with normal activity 3	Ughs activity Severe comorbidity	Bed / chair- ridden with no or tittle activity 5 Very severe multiple co- morbidity 5 Severe Severe
1) 2) 2) Total Score =	Physical exam Decreased fai Sign of muscle Sum I above 7 com Status: Based on this	Name /improved (Disease and its relationship to nivirition in the interest of	Difficulty with ambulation In requirements 2 Mild comorbidity 2 Mild 2 Mild	Difficulty with normal activity 3	Ught activity	Bed / chair- ridden with no or tittle activity 5 Very severe multiple co- morbidity 5 Severe Severe
1) 2) 2) Total Score =	Physical exam Decreased fai Sign of muscle i Sum I above 7 com Status : Based on this Well Nourished Moderately Ma	Name /improved (Disease and its relationship to nivirition in the interest of	Difficulty with ambulation In requirements 2 Mild comorbidity 2 Mild 2 Mild	Difficulty with normal activity 3	Ught activity	Bed / chair- ridden with no or tittle activity 5 Very severe multiple co- morbidity 5 Severe Severe
1) 2) 2) Total Score =	Physical exam Decreased fat Sign of muscle to Sign of muscle to Sum I above 7 com Status : Based on this Well Nourished Moderately Ma Severely Malno	Name /improved (Disease and its relationship to nivirition in the interest of	Difficulty with ambulation In requirements 2 Mild comorbidity 2 Mild 2 Mild	Difficulty with normal activity 3	Ught activity	Bed / chair- ridden with no or tittle activity 5 Very severe multiple co- morbidity 5 Severe Severe
B) 1) 2) Total Score =	Physical exam Decreased fat Sign of muscle to Sign of muscle to Sum I above 7 com Status : Based on this Well Nourished Moderately Ma Severely Malno	Name /improved (Disease and its relationship to nivirition in the interest of	Difficulty with ambulation in requirements} 2 Mild comorbidity 2 Mild 2 Mild	Difficulty with normal activity 3 Moderate comorbidity/ age >75 years 3 Moderate 13 Moderate (15 to 16) (15 to 16)	Ught activity	Bed / chair- ridden with no or tittle activity 5 Very severe multiple co- morbidity 5 Severe Severe

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
10100	NETO years ald pemale come to clocuret pain was assessed to be well-nowwished as evident by SONA (100- TADM/SHTN). patient shifted to athleto Ror moceduce (CAG). Iceptonne	r: se) f
26/12/23	patient received to poidioil lowge Educated the patient of January on 1600 calories, Low pat, Low Salt, Miosetic diet on dischough Emphasized on shall freque neals & Low glyceric control. Diet chart given on disharge.	



Handed over to



Mrs.UMA P

56/Female/MHI202381+95 26/12/2023/IPH2023002598

Dr.G. GNANAVELU





Every heart beat counts

(A Unit of United Alliance	Healthcare Pvt Ltd)		(Every	neart neat	counts
PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES BIFASCICULA & BLOCK Diagnosis: AWKMAL CV FUNCTON Allergies if any:								
	TLDM.		^`					
From (Area)	To	(Area)	Date	Time	Reaso	n for Transfer / Na	ame of Pro	cedure
R 1_	R1 cath lab 26/12/23/13-00 CACY							
Method of Tran	sfer: 🗌 On Bed	I ☑ On Wheeld	chair 🗌 On S	Stretche	r	·		
ASSESSMENT General condit	OF PATIENT: ion of Patient:	Conscious [☐ Semi-cons	scious [☐ Un-consc	ious		
Language Barr	ier: ☐ Yes ☐ Mo	o ☐ If Yes, spe	ecify:		_			
Fall Risk Categ	ory. Low Risk	☐ Medium Ris	sk 🗌 High R	lisk	~			
Vital Signs (to be	e documented at	the time of shif	fting):					
Temp (°F)	RR (breaths/m	in) Puls	e (beats/mir	1)	SpO ₂ (%)	BP (mmHg)	Pain	Score
98. E	Doppm	6	malde		louy.	120/84	Olu	O
Any critical info	ting Scale (>12 y tion given: rmation: commendation:	((ventilator /	comatos	se)			
	Signature	Nai				Emp. No.	Date	Time
Handover by	Aw		Jane	thi'		02-8-2	>6/2/2	12.00
Handed over to			V· Q	biray	je,	<u>mm</u> .	26/12/2	13.00
After Procedure: Procedure completed: ☐ Yes ☐ Yes Any critical information: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐								
Vital Signs (to be	RR (breaths/m		e (beats/mir	, <u>, </u>	SpO ₂ (%)	BP (mmHg)	Pain	Score
Temp (°F)	Tin (breatis/iii		1 . 1.	3-	100 %	1000	\ 	Z ₁₀
Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months) ☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years) ☐ Numerical Rating Scale (>12 years) ☐ CPOT (ventilator / comatose)								
	Signature	Nar	me ,			Emp. No.	Date	Time
Handover by		- 7	u. Ah	rese	2,]	ω_{0}	8/10/03	12./2

0280





ANGIOGRAM / CORONARY ANGIOPLASTY

Mrs.UMA P

*56/Female/MHI202381495

Patient Name 26/12/2023/IPH2023002598

Consultant:

Sex: M/F Dr.G. GNANAVELU

Dr. ANAVIT has explained that I have the following condition:

Fat (cholesterol) and calcium can build up in the arteries like rust in old pipes. It can stop the flow of blood to the heart. This can cause anging 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 xrays 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.

UHID

RISKS OF THIS PROCEDURE

The risk of coronary angiography depends on:

(iii) Your age and general health (i) The nature of coronary artery disease (ii) The pumping status of the heart 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: P acknowledge that Dr. A. MANAVELV..... 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	B Mino.	UMA	26/12/23	13.00
witness	188	ARUNA CHALAM	26/12/28	13.00
Doctor	(lozale)	no given	26/12/25	13.00
Interpreter				





இருதய ஆன்ஜியோகிராம் பரிசோதனைக்கான ஒப்பம்

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

நிலை மற்றும் செயல்முறை

பழைய இரும்புக் குழாய்களில் துருபிடிப்பதைப் போல். தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாரடைப்பிணை ஏற்ப்டுத்துகிறது. 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 (இடதுபக்க இருதய கீழறை) இந்த கான்ட்ராஸ்ட் மீடியும் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்படவும் மற்றும் அது எவ்வாறு பம்ப் செய்கிறது என்பதை மதிப்படவும் மற்றும் அது எவ்வாறு பம்ப் செய்கிறது என்பதை மதிப்படவும் மற்றும் இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகீட்சையை மேற்கொள்ள முடியும். இனை பை-பான் அறுவை சிகீட்சையாகவும் இருக்கலாம் அல்லது ஆன்ஜியோபிளாஸ்டி (பனுன் வடிவம் கொண்டதொகு சிறிய சாசேஜ் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

கீச்சையல்முறையிலுள்ள 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 தீனிர இடர்பாடுகள் பின்வருமாறு. ஆனால் கிவைகள் மட்டுமே முழுமையான இடர்பாடுகள் அல்ல

, 10.00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிவீதம்)	(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 ஆன்ஜியோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதீர் பாதீப்பு காரணமாக அதீக வாழ்நாள் அச்சுறுத்தல் இடர்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	 (I)இதயும் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகீச்சை தேவைப்படும் (j) குத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகீச்சை சரியாடு. இதனால் மருத்துவமளையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (1) 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

சையல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

	கையெழுத்து	பெயர்	தேதி	நேரம்
நோயாளி (பாதுகாவலர்) உறவுமுறை				
சாட்சி				
மருத்துவா	;			
மொழிபெயர்ப்பாளர்				







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TRANSRADIAL CORONARY ANGIOGRAM REPORT

Patient Name: Mrs. UMA.P		ID:	MHI202381495	
Age/Gender :	56 F	IPH:	IPH2023002598	
Cath No. :	3469		DOP:	26.12.2023
Done by	Assisted by	Technician	Physician assistant	
Dr.Gnanavelu	Ms. Panchavarnam	Mr. Pandiyan	Ms. Shalini	

DIAGNOSIS: T2DM; DYSLIPIDEMIA; HYPOTHYROID; BIFASCICULAR BLOCK; NORMAL LV FUNCTION

Access: Right radial artery ,

Total exposure time: 205.8"

Hardware used: 5F sheath, 5F TIG

Total DAP: 18.35 Gy.cm²

Contrast used: CONTRAPAQUE 50 ml

Total RAK: 89.53 mGy

Medications given: Inj NTG 200 mcg & Inj Heparin 2500 IU IA

Hemodynamic data: Aortic pressure: 126/75(93) mmHg; HR 82 bpm; SpO2 99%

Selective Coronary angiogram done in multiple angulated views:

ARTERY	FINDINGS
LEFT MAIN	Normal. Bifurcates into LAD & LCx. Calcified coronaries.
LAD	Type 3 vessel. Proximal LAD has luminal irregularities. Mid LAD has 70-80% tubular stenosis with calcification. Distal LAD has 50-60% tubular stenosis. Gives 3 diagonals which are thin vessels with luminal irregularities.
LCx	Nondominant. Proximal LCX after OM1 shows 30% discrete stenosis. Distal LCX is a thin vessel with luminal irregularities. Gives 4 OMs. OM1 and OM2 are major vessels which have luminal irregularities.
RCA	Dominant. Proximal RCA is normal. Mid RCA has 70% tubular stenosis. Distal RCA has 30% discrete stenosis. PDA and PLV are normal.
IMA	LIMA & RIMA are normal.

FINDINGS: RIGHT DOMINANT SYSTEM; SIGNIFICANT CALCIFIC LAD & RCA DISEASE

ADVICE: IVUS GUIDED PTCA TO LAD & RCA

Dr. G. GNANAVELU, MD, DM

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

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

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Kumbakonam 044-2473 4455 Chengalpattu 044-27426829 Villupuram 04146-242000 Heart Institute 044 - 4310 8959 Institute of Pulmonology 044-2473 4454

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

MHI/HOSP/2022/118



Mrs.UMA P 56/Female/MHI202381+95 26/12/2023/IPH2023002598 Dr.G. GNANAVELU

MHI/NUR/2022/048

DATE & TIME	Observation / Action	Signature with Emp.No
26/12/23	Admission vote.	-
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	Pt av line patient	A
13:15	> CHG procedige Started. PI Perdia	
	offery approach	6501
13:15	SENT NITE soo mel 12NI: Heparin	
	25080 TH given (of DR(1/2)(SIV)	
13.15	> HR: 82 12/1/10/10 Bp: 125/78 (83) m/m Hg	0630
	Spor 100/ Vital Stable	
13:30	->1716 protectule done	
	Signature Name Emp . No. Date	Time
Document endorsed by		
. 4	Sastry 00/0 06/12/2	3. <i>[13-30]</i>



	DATE &	Observation / Action	Signature
	TIME		with Emp.No
26/12/2	13:40	=> Pt Padral Orter Shorth removed tight pressur bandage applied	
	13:45	ho ooting no hounton =) pt shyles cash dos to be	D
,	13.45		1020
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		discharge pt is stake	
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SAFE PROCEDURE CHECKLIST Adapted from WHO Safe Surgery Checklist

MHI/OT/2022/086 Medway Heart

Mrs.UMA P

56/Female/MHJ202381495 26/12/2023/IPH2023002598

Name of the Procedure :	CPG_	Location: Cath W	Date & Time	6/12/23 Dr.G. GNANAVELU				
Does the Procedure involve	Procedural Sedation : [Yes □No						
SIGN IN 13 10 Before Induction of Procedural S	edation	TIME OUT 3 - / 5 After procedural Sedation and before procedure		SIGN OUT 3 30 When Doctor indicates that the Procedure is completed				
(Anaesthetist / Qualified Physicia Sedation + Nurse + Technician + Do	n administering Procedural	(Anaesthetist or Qualified Physici	an administering Procedura performing the Proced	al Sedation + Nurse + Technician + Doctor lure				
Patient Confirmation		All team members introduce themselves by Name and R	ole	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	☐¥es	Procedures ()	.□Yes	Name and site of all specimens / investigations Yes NA				
Side	□RI □LI □NA	Side Rt Radial Onteny cypon Expected Blood loss NA	OUCURT LILI LINA	confirms labeling and sent to lab				
Consent	Yes	Position MDINU	1 Yes	Any recovery concerns : ☐ Yes ☐ None				
Known Allergy	☐ Yes ☐ Nø If yes, plaese specify	Consent // Required equipment and implants available	∠ Yes NA	if Yes, Pis. specify:				
Difficult airway / aspiration risk	□ No □ Yes, equipment	Essential Imaging displayed	☐ Yes ☐ NA	Epse.				
/ dentures	and assistance available	Antibiotic prophylaxis within last 60 minutes	☐ Yes ☐NA					
Possibility of hypothermia	☐ No☐ Yes, warmer in place	Name of the Antibiotic given Venous Thromboembolism Prophylaxis Provided	Yes FINA	Any Equipment / instrument problem that needs to be addressed:				
All concerned anesthesia equipment	and medication check complete	Anticipated duration briefed	□Yes	If Yes, Pls. specify:				
Spo2 DNBP DOther	s pls. specify	Anticipated blood loss briefed	☐Yes ☐NA	[
Pre OP medication taken	☐ Yes ☐ 100	Adequate fluids and blood available Team briefed on any critical or unexpected steps	☐ Yes ☐NA ☐ Yes	Corrective action :				
Required equipment for procedure available	□Yes □NA	For procedural sedation cases Any patient specific concerns: Intra procedure glycernic control Any concerns about sterility	Yes Nope Yes MA	Corrodate addition .				
Anaesthetist / Doctor diving Procedural Sedation Date : Time :	Doctor performing the Procedure: Date: 26 12 25 17 17 17 17 17 17 17 1	Nurse Nipanchautarm Date 26/23 Time:	Date: 156/12/23	Others Please Specify: Old Date: Time:				







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Procedure Monitoring Sheet (Cath Lab)

Patient	Mama	
Lancin	INALLIE	

Mrs.UMA P

56/Female/MH1202381+95

UHID / IP:

26/12/2023/IPH2023002598

Dr.G. GNANAVELU THE OWNER WAS INVESTIGATED BY AND THE BUILD Age/Sex: 564/ Foral

Ward Unit: D)_

Consultant: Diagnosis: Pre Procedure Checklist (Please tick appropriately – To be filled by the Ward Nurse) **PARAMETERS** YES NO NA Vital signs: BP:...... Pulse:..... RR:...... SPO2: Urine voided Bowel preparation Pre-procedure medication administered Procedure site marked Skin preparation done 11.00 NPO 11.00 Loose Tooth removed Contact lenses / Eye glasses removed Prosthesis present Jewellery/Nail polish removed Checked for Allergies (Drug / food) IV line/In-situ Consent taken Investigation reports / Documents received Date & Time: 26/12/23 at. Signature of Nurse: N Intra - Procedural Record (To be filled by the Cath Lab Nurse) HR / min RR / min Medication / Remarks Time BP mmHg SpO₂% Sign. of Nurse

				Post Proce	edure Follow Up	•	_		A .	٠
	Time:			13.30		Route:	RI Par	dial	ordory	approved
	Compli	cation : f	Ji I	·			10 ~ 0			. If the second second
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				00			اطو	12/22	10:1/o	,





Mrs.UMA P

56/Female/MH1202381+95 26/12/2023/IPH2023002598

Dr.G. GNANAVELU





Every heart beat counts

	BRADEN S	CALE FOR PREDICITI	NG PRESSURE INJUR	Y RISK Time:	M	1	
SENSORY PERCEPTION ability to respond meaning-fully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch,or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned OR had some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort	4	4	
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned	2. Very Moist Skin is often, but not always moist, Linen must be changed at least once a shift	3. Occasionally Moist Skin is occasionally moist, requiring an extra linen change approximately once a day	4-Rarely Moist Skin is usually dry, linen only requires changing at routine intervals	4	4	
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non- existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	walk severely limited or non- existent. Cannot bear own weight and / or nust be assisted into chair or wheelchair in bed or chair Walks occasionally during day, but for very short distances, with or without twice a day and inside assistance. Spends majority of each shift in bed or chair				
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 Lin Itation Makes major and frequent changes in position without assistance	7	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	meat or diary products per day. Occasionally will take a dietary	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, diary products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and diary products. Occasionally eats between meals. Does not require supplementation	4	4	
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	3.No Apparent Problem Moves in bed and in chair independentl strength to lift up completely during move. Nor chair	3	2)	<u></u>	
Score	Interpretation: Minimal Risk: 23 - 19; At Risk ;	Mild Risk: 18 - 15; Moderate Risk: 14 - 13; H	High Risk: 12 - 10; Severe Risk: 9 - 6	Initial & Emp. No. of Sr. Staff Nurse:	7_	1	

RRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK





PAIN RE-ASSESSMENT & MONITORING CHART

Mrs.UMA P

56/Female/MHi202381+95 26/12/2023/IPH2023002598

Dr.G. GNANAVELU

MHI/NUR/2022/052



Every heart beat counts

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
12·b0	ol to	No Pain	7			D	Jacker
		NO Pain pa pa pac	stin	the b	cate las at 13.00 from cota bus at 12.45		
1400	0/20	No poein			_	A	John
1500	1/20	10 pain	•	_		an:	Juloo
18-10	0/0	Mo pain				An	Joef
17.10	0/10	Mu gain	-	•		A200) alp a
/two	2/2	No pain	4			Arre)oefour
			PC	<u></u>			

	,																		
					Į i							_							
Į				_												-			
. 4			_			:					_	~							
PIPP	ne	T	6 or less =	: Minimal to no	pain	Р	AIN SCA	LES			_				<u>.</u> .	<u>. </u>	<u>.</u>	· .	
(28 weeks to <	38 wee ES	eks)	>12 = Mod	scale is used	e pain - Pharn I for infants >	easures nocological intervent than or = 38 weel ndertaken, and ana	ks of gestation						ES sc		> 4,	<u>,</u>			• 1
FLACC : (2 months -	Scale	- 	<u> </u>			iscomfort, 4-6: Mod							_	,	,				•
Wong-Bake Pain Ratin (7 years - 1	ng Scale	•	O No Hurt	2 Hurts Little Bit	4 Hurts Little More	6 Hurts Even More	8 Hurts Whole Lot	10 Hurts Worst	C No.	Numeri 0 1	cal Ra	ting \$	 	(age	`6 ^ 4	re thai	12 y	9	- 10 - ↑
Critical ca Observation T (ventilator / c	Tool (CP	POT) se)	BODY MOY COMPLIAN VOCALIZA MUSCLE T	VEMENTS: 0 - NCE WITH VE NTION (non-int TENSION: 0 - F	Absence of m NTILATION (in Subated patien Relaxed, 1 - Te	eutral, 1 - Tense, 2 - 0 lovements or norma ntubated patients): nts): 0 - Talking on n nse, Rigid, 2 - Very 1 oderate Pain; 5 - 8:	I position, 1 - 0 - Tolerating Iormal tone or Tense, Rigid	Ventilator or	- Restlessn Movement	ess / Agitat , 1 - Cough	ion ing but t		ng, 2	- Fighti	•	ntilator	.:	:	•
Non-pharma Interver		cal	Cutaneous Thermal Ti	s Stimulation a herapies (no k	and massage: onger than 15	nvironment; B - TV; E - Positioning; F - to 20 minutes): G - (ulation (TENS): J - II	Rubbing / Ma Cold applicati	issage the ski ion; H - Hot a	in oplication; I	- Shortway			Individ	lual Co	ounsel	ing; L - I	amily	counse	ling





F Mrs.UMA P 56/Fernale/MHI202381+95 26/12/2023/IPH2023002598 Dr.G. GNANAVELU



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

	ign a door of the (120) in parameter hos. I to s,				(-)			<u>-</u>
		3P10R						-
		15-00						
S. No.	PARAMETERS	<u> </u>						
1	Active cancer (on-going treatment or diagnosed within 6 months or palliative care)	0	<u> </u>					
2	Bedridden recently >3 days or major surgery within four weeks	0						
3	Calf swelling >3 cm compared with asymptomatic side, measured at 10 cm below tibial tubercle (Assess for both legs)	0						
4	Collateral (nonvaricose) superficial veins present (Assess for both legs)	Ø						_
5	Entire leg swollen (Assess for both legs)	10			_			
6	Localized tenderness along the deep venous system (Assess for both legs)	0						
7	Pitting edema, greater in the symptomatic leg (Assess for both legs)	0						
8	Paralysis, paresis, or recent plaster immobilization of the lower extremity (Assess for both legs)							
9	Previously documented DVT (Assess for both legs)	0						
10	Alternative diagnosis to DVT as likely or more likely (Assess for both legs) / Co-morbidity like ESLD / Renal disease, Renal failure, CCF Cellulitis (commonly mistaken as DVT), Dependent (stasis) oedema, Lymphatic obstruction. Septic arthritis, Cirrhosis, Nephrotic syndrome, Calf muscle tear or strain, Haematoma (collection of blood) in the muscle, Sprain or rupture of a leg tendon, Fracture.							
	FINAL SCORE	10						
Low R	tisk: -2 to 0 Moderate Risk: 1 to 2 High Risk: 3 to 8	Ton						
	DVT prophylaxis started	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	□ Yes □ No
	Signature & Emp. No. of RN	10/4						
	Signature & Emp. No. of Sr. RN	9/2						
		2000						



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Mrs.UMA P

56/Female/MHI202381+95 26/12/2023/IPH2023002598

Dr.G. GNANAVELU



MHI/NUR/2022/046

Where heart beat never stops..

MODIFIED MORSE FALL RISK ASSESSMENT CHART

		,	√> . 1₁	5						
W-d-ld-	Date	24/14	26/14							
Variables	Time	12041	1620							
History of falling	No	O	6	0	0	0	0	0	0	0
(immediate or within 6 months)	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis	No	0	0	0	0	0	0	0	0	0
(≥ 2 medical diagnosis)	Yes	13	(15)	15	15	15	15	15	15	15
Intravenous Therapy /	No	Ø	Ø	0	0	0	0	0	0	0
Heparin Lock / Tubes Insitu	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID		~	(6)							
None / Bed Rest / Nurse Assist		<u> </u>	6	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT		6	20							
Normal / Bed Rest / Wheel Chair		6	<u>(a)</u>	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS		_								
Oriented to own stability		6	(b)	0	0	0	0	0	0	0
Overestimated or forgets limitations		15	15	15	15	15	15	15	15	15
MEDICATIONS Includes PCA / opiates, diuretics, laxatives, hypnotics, sedatives,	No	6	Ó	0	0	0	0	0	0	0
immunosuppresent, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	Yes	15	15	15	15	15	15	15	15	15
Total Score		15	15							
Low Risk (0 - 24)		W								
Medium Risk (25 - 44)										
High Risk (45 or above)				-						
Signature & Emp. No. of RN		Mor	ym,	, 						
Signature & Emp. No. of Sr. RN		12	800	!						
	-	<u>9</u> 0 -	24: Low	Risk; 2	5 - 44: N	ledium	Risk; 45	or abo	ve: High	Risk

)1	<i>γ</i>	2						٠.
INTERVENTIONS	Date	94	6/12						,	
INTERVENTIONS Tick as per the Risk Score	Time	11.46	16.3	<u> </u>	-				 	
	Tillile	- '·	10			-	 	 		-
Low Risk Interventions (0 - 24)										}
Familiarize the patient with the immediate surround				ļ		 	}	*	 	
Remind the patient to use call bell before getting ou		<u> </u>				<u> </u>	<u> </u>	 	 	ļ
Keep the two side rails in the raised position at all ti	imes tor									
all patients regardless of age	:al.:_ al	-			ļ	+	+	+	 	 -
Keep the call bell, bedside table, water, glasses win patient's easy reach			· .							
Remove excess equipment or furniture to make	a clear			ł						
path				<i>^-</i>	 	1	1	 	├ —	
Keep the patient's bed in the low position at all times during procedure	s except	_		-(1	1					
Teach fall-prevention techniques, such as sitting it	up for a		1		1					
moment before rising from the bed									<u> </u>	
Bed wheels should be locked		~_								
Encourage family participation in the patient's care										
Ensure that floor of the bathroom is dry and not slipp	pery		/							Ī
Review medications for potential side effects the		<u> </u>								1
promote falls		1	 							
Use safety belts during movement in wheelchair		-	-				1			1
The patients are not ambulated by themselves. The	ev are to			<u> </u>			1	 		
be ambulated only with assistance	•				1					1
Medium risk interventions (25 - 44)		-		ļ		ļ	<u> </u>		ļ	<u> </u>
Apply all the low risk interventions]								
Tie yellow fall risk tag in the bed and Wheel chair / St	retcher			 			1			1
Make sure that proper transfer precautions are in		 		-		 	1			
for heavy or debilitated patients in a bed or wheel		İ								
on a toilet seat	Oriali Oi									
Use restraints and bed monitors as ordered by the c	foctor	t		†		1	1	1	†	t
Allow the patient to ambulate only with assistance	20001			<u> </u>	1		+ -	 	 	+-
Consider peak effects of the medications that effects	rts level	 		 	+	+	1	 	 	
of consciousness, gait and elimination when p										1
patient's care	nammig									Į.
Do not leave patients unattended in diagno	etic or				 	+	-	+	<u> </u>	-
treatment areas	one or	:								
Accompany the patient while going to bathroom		-		}	+	+	1		1	-
Advice the patient to use grab bars near the toilet, b	acthub	-				 	1		<u> </u>	
and shower	Januub,				•					
Make sure the family and other visitors understa	and the	 			 	-	 -	+	 	+
restrictions mentioned above	u10 1116	`								
High-risk interventions (45 or above)										
Apply all the low and medium risk interventions		1	I	}		[1		
Tie red fall risk tag in the bed, wheel chair and stretcl	her	 		 -	+	1	+ -	+	-	+
Locate the high-risk patients in a room close to the		 		2.7	+	 	+-	 	 	-
station	Hulbes	.		'		1		1		
Answer these patients call bells as quickly as possib	nle .	 		;	+	 -	+	1	 	+
Provide a commode at bedside (if appropriate)	<i>7</i> 16		•		+	 	 	+ -	1	+
Urinal/bedpan should be within easy reach (if appropriate)	noriato)	 			 	1	+	+	 	
Encourage family members or other visitors to st					+	 	+	1		
them	wy willi									
If appropriate, consider using protection devices	: safety	 	-		1	 	+	+	1	
belts	. Galety		_ & _	Ľ						<u> </u>
Signature & Emp. No.	of RN	1	178	ţ			1			
Signature & Emp. No. of S	Sr. RN	1	**	.	1	<u> </u>	1	1	!	1
Ciurusule di Lillu. 110. Ul d	: :: :		. * 1/	1/		1	1	1	1	1

MEDWAY HOSPITALS

KODAMBAKKAM (HEART)

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

care@medwayhospitals.com

Registration No : MHI202381495 Patient Name : UMA P

Age : 56 Gender : Female

Bill No : MMH/HM/IPH00612 Bill Date : 26/12/2023 7:30:41PM

Ward Name : RADIAL LOUNGE Bed Name : V_RL-6

NO DUE





