



MRD CHECKLIST

PARTICULARS	YES	NO
- IP Number allocated to each Patient	/	
- Name, Age & Sex of Patient	/	
- General Admission Consent	/	
- Initial Assessment of Patient / Diagnosis	/	
- Nutritional Assessment by Consultant	/	
- Plan of care counter signed by the Consultant	/	
- Treatment Orders - Date, Time, Name & Sign.	/	
- Medication Order / Drug Chart - Date, Time, Name & Sign.	/	
- Vital Signs Chart (TPR Chart)	/	
- Intake Output Chart	/	
- Drug Chart (Duly filled)	/	
- Anaesthesia Consent - (8 thing) - Date, Time, Name & Sign. of both Patient & Anaesthetist		
- Anaesthesia 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	/	



Medway Hospitals

The way to better health

(A Unit of United Alliance Healthcare Pvt Ltd)

Mr.SENTHIL KUMARAN.P

59/Male/MHI202481705

09/01/2024/IPH2024000075

Dr.K.JAISHANKAR



MHI/IPD/2022/002

Kumar.



Where heart beat never stops...

ADMISSION SLIP

Admitting Doctor: Dr. Jaishankar Speciality: Cardiologist

Advised Date & Time: 12.00pm @ 9/1/24

Provisional Diagnosis: EXERCISE INDUCED ANGINA
CAG - 10 V2 (11.2-40/8)
Moderate LV dysfunction.

Reason for Admission: ☐ Medical Management ☐ Surgical Management
☐ Others (please specify details) CAG.

Admission Type: ☒ Day Care ☐ ER ☐ Ward
☐ ICU (Specify details)

Surgery / Procedure Name (if planned):

CAG.

Blood Product Requirement: ☒ No ☐ Yes (Kindly specify details of components required in space below)

Expected Duration of Stay: Day Care.

Expected Cost of Treatment (as per Financial Counseling Form):

Payer: ☒ Self ☐ Insurance ☐ Others:

Instructions to Nurse (if any): collected cath pack.

=> TO do blood Investigation & collect blood reports.

Any other Instructions (if any):

Doctor's Signature <u>[Signature]</u>	Name <u>Dr. Jaishankar.</u>	Reg. No. <u>49448</u>	Date <u>9/1/24</u>	Time <u>12.00pm</u>
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For admission desk staff only:

Room Category: ☐ General Ward
☐ Single Room
☐ Twin Sharing
☐ Deluxe Room
☐ Suite Room
☐ Others _____

Admission intimation Receipt Details

Admission Time in HIS

Date	Time	Date	Time
9/1/24	12:43 PM	9/1/24	12:43 PM

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 Signature	Name	Emp. No.	Date	Time
	S. Vignesh	0262	9/1/24	12:43 PM

**Medway Hospitals***The way to better health*

(A Unit of United Alliance Healthcare Pvt Ltd)

**Mr. SENTHIL KUMARAN.P**

59/Mulc/MHI202481705

09/01/2024/IPH2024000075

Dr.K.JAISHANKAR



MHI/HOSP/2022/129



Where heart beat never stops...

ADMISSION FORM

Marital Status M	Full Address P SENTHIL KUMARAN 5 OM SAKTHI NAGAR, 3rd CROSS STREET, Chavadi, Cuddalore.	Telephone Number 9486101322 9940954935
Occupation RL		
Referred from Saraswathi Kumaran MHI Hospital	Date of Time of Admission 9/1/24 12.45PM	Date & Time of Discharge 9/1/24 @ 18.15
UNIT RL		Total No. of Days 6 HOURS 15 MINUTE.
MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If Yes AR No. :

FINAL DIAGNOSIS	ICD Code
EXERTIONAL ANGINA	I20.8
CAG - DOUBLE VESSEL DISEASE (11-2-2018 KALYANHO)	I25.1
MODERATE LV DYSFUNCTION	I50.1
SYSTEMIC HYPERTENSION.	I10
TYPE II DIABETES MELLITUS.	E11.9

DATE	OPERATION / PROCEDURES	ICPM Code
9/1/24	CORONARY ANGIOGRAM DONE ON 9/1/24 ← TRIPLE VESSEL DISEASE.	88.50
DATE	TYPE OF ANESTHESIA	
9/1/24	<input type="checkbox"/> GENERAL <input type="checkbox"/> SPINAL <input checked="" type="checkbox"/> LOCAL <input type="checkbox"/> REGIONAL <input type="checkbox"/> EPIDURAL	

DISCHARGE STATUS		
<input type="checkbox"/> Cured <input checked="" type="checkbox"/> Improved <input type="checkbox"/> Unchanged	<input type="checkbox"/> Discharge at Request <input type="checkbox"/> Against Medical Advice <input type="checkbox"/> Absconded <input type="checkbox"/> Transferred to	<input type="checkbox"/> Expired < 48 hours <input type="checkbox"/> Expired > 48 hours <input type="checkbox"/> Post-Operative Death
Signature of the Consultant: <i>[Signature]</i> 123619 Signature of Medical Records Officer: <i>S. Alen Jay</i> 2038		

S.No. : 5

AUTHORISATION FOR TREATMENT I PAYMENT

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

I hereby under take to settle all the bills for hospitalisation charges related to me/the patient named overleaf on a periodic basis. In any case, I shall pay all the dues before getting discharged from the hospital.

However, in case I fail to pay the charges due to the hospital as agreed above, I hereby authorise the hospital to transfer me/the patient to any other hospital/institution for further treatment as deemed fit and proper by the hospital authorities.

I also acknowledge having been informed if the General Rules and Regulations of the Hospital and that all cash, jewellery and valuables belonging to the patient or theis attendants have been removed to a place of safety / handed over to the next of kin and I absolve the hospital of any responsibility with regard to any loss.

I have read out and explained the contents of the above to the Signatory in his vernacular .

சிகிச்சை, பணம் செலுத்துதல் முதலியவை செய்ய அதிகாரம் வழங்குதல்

இதன் மூலமாக நான் நிர்வாகம், மருத்துவம், தாதியர், ஏனைய மருத்துவ ஊழியர்கள் எனக்கு / நோயாளி
.....க்கு தேவைப்பட்ட சோதனைகளை செய்து மருந்துகளை கொடுக்கவும், மயக்க
மருந்துகள் கொடுத்து செய்முறைகள்/அறுவை சிகிச்சை செய்யவும் அதிகாரம் வழங்குகிறேன். நான் / இதில் குறித்துள்ள நோயாளின்
செலவுக்கான தொகை முழுவதும் செலுத்த இதன் மூலம் உறுதி அளிக்கிறேன்.

மேல் கூறியது போல் வேளை நான் தங்கள் மருத்துவத்திற்கான செலவுகளை கட்டத் தவறினால் என்னை நோயாளியை வேறொரு
மருத்துவமனைக்கு, பிற சிகிச்சை / அறுவை சிகிச்சை செய்ய இடமாற்ற ஒப்புதலை எனது உறவினர்கள் மூலமாக பெற நான் அதிகாரம்
அளிக்கிறேன்.

மருத்துவமனையின் பொது சட்ட திட்டங்கள் பற்றி தெரிவிக்கப்பட்டிருக்கிறேன்.

நோயாளிக்கு உரிமையான எல்லா பணம், நகை மதிப்பிடக்கூடிய பொருட்கள் யாவும் பாதுகாப்பான இடத்திற்கு மாறுபட்டுவிட்டன / அல்லு
நெருங்கிய உறவினரிடம் கொடுக்கப்பட்டுள்ளது. இந்த மருத்துவமனை எனது/நோயாளியின் எந்தவித நஷ்டத்திற்கு பொறுப்பில்லை
என உறுதி செய்கிறேன்.

மேற்குறிப்பிட்ட அனைத்தும் எனக்கு விவரிக்கப்பட்ட பிறகுதான் கையொப்பமிட்டேன்.

செவிலியர் கையொப்பம்

Signature of Admitting Nurse

9/1/24

தேதி

Date

எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of the Patient / Relative / Guardian

M. MANOWAR

உறவுமுறை

Nature of Relationship



Mr.SENTHIL KUMARAN.P

59 / Male / MHI202481705

09/01/2024 / IPH2024000075

Dr.K.JAISHANKAR



MHI/IP/2022/008



Every heart beat counts

GENERAL CONSENT FOR ADMISSION

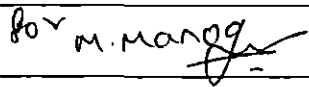
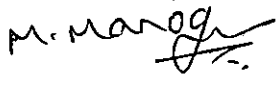
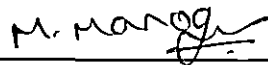
I, Senthil Kumaran the ☒ Patient or ☐ Representative of patient have
(please tick the correct option above and below)

☐ 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 discharge.

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

	Signature / Thumb Impression*	Name	Date	Time
Patient		P. SENTHIL KUMARAN	9/1/27	12:45 pm
Surrogate/Guardian (if applicable #)		M. MANOGAR. (Write name and relationship with patient)	9/1/27	12:45
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		M. MANOGAR	9/1/27	12:45 pm
Interpreter (if applicable)				

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



JCI ACCREDITED



NABH ACCREDITED



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DAY CARE DISCHARGE SUMMARY

IP No.	IPH2024000075	D.O.A	: 09/01/2024
UHID	MHI202481705	D.O.P	: 09/01/2024
Name	Mr. SENTHIL KUMARAN. P	Room No.	: RL
Age / Gender	59 Years / MALE		
Consultant	Dr. JAISHANKAR.K MD., DM., FIAMS Director and Clinical Lead Cardiology and Electrophysiology	D.O.D	: 09/01/2024

DIAGNOSIS:

EXERTIONAL ANGINA

CAG -DOUBLE VESSEL DISEASE (11.2.2018, KALYAAN HOSPITAL)

MODERATE LV DYSFUNCTION

SYSTEMIC HYPERTENSION

TYPE II DIABETES MELLITUS

PROCEDURE: CORONARY ANGIOGRAM DONE ON 09.01.2024 – TRIPLE VESSEL DISEASE.

BRIEF HISTORY:

Mr. Senthil Kumaran. P, 59 years old male, presented with complaints of breathlessness & mild chest pain while climbing stairs. Complaints of shoulder pain. He was advised Coronary angiogram and referred to Medway Heart Institute on 09.01.2024 for which he has been admitted.

No H/O fever, vomiting, diarrhea.

Known case of systemic hypertension, Type II diabetes mellitus on medication.

N/K/C/O CVA, hypothyroidism.

ON EXAMINATION:

HR: 74bpm ; BP: 152/83mmHg ; SPO₂ : 97% in room air

CVS: S1S2+ ; RS : Clear ; CNS: NFND; Abd: Soft

INVESTIGATIONS:

BLOOD: Hb- 15.6gm/dl, TWBC – 7620 cells/cumm, PLT – 258000 cells/cumm, Urea – 38mg/dl, Creatinine – 1.22mg/dl, Na⁺ - 139 mmol/l, K⁺- 5.30 mmol/l, INR – 0.8.

ECG: sinus rhythm, HR – 66bpm, LVH(+)

ECHO: All chambers normal sized. RWMA (+) septum, apex, basal and mid inferior hypokinetic. Moderate LV systolic dysfunction. EF – 38%. Grade I diastolic dysfunction. Normal RV systolic function. IAS /IVS intact. Aortic valve sclerosis. No AS/ AR. Other valves are structurally normal. Trivial MR. Trivial TR. No PAH. IVC normal in size and collapsing. No clot / vegetation /effusion.

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

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94557 94557
1800 572 3003

Medway Group of Hospitals

Kodambakkam 044-2473 4455	Mogappair 044-26530011	Chengalpattu 044-27426829	Villupuram 04146-242000	Kumbakonam 044-2473 4455	Kakinada 0884-233367
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E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

Medway Centre of Excellence (Chennai)

Heart Institute 044 - 4310 8959	Institute of Pulmonology 044-2473 4451
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MHI/HOSP/2022/118



NAME: MR. SENTHIL KUMARAN. P

UHID: MHI202481705

IP.NO: IPH2024000675

**COURSE IN THE HOSPITAL:**

Mr. Senthil Kumaran. P, 59 years old male, underwent Coronary Angiogram by **Eighty Heart Institute** on 09.01.2024 which revealed **TRIPLE VESSEL DISEASE**. Post procedure was uneventful. He is advised for **CABG** (grafts to LAD, MAJOR OM & PDA/PLV). His medications are optimized and is being discharged in a stable clinical condition.

ADVICE MEDICATIONS:

SL. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH FOOD	DURATION
			M	A	N			
1	TAB. ZYROVA C10 (ROSUVASTATIN & CLOPIDOGREL)	75/10 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE (TO STOP 5 DAYS BEFORE SURGERY)
2	TAB. RACIPER D (DOMPERIDONE AND ESOMEPRAZOLE)	40 MG	0	0	1	ORAL	BEFORE FOOD	TO CONTINUE
3	TAB. VERTIN 24 OD (BETAHISTINE)	24 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE
4	TAB. OLMEZEST BETA (OLMESARTAN & METOPROLOL)	25 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
5	TAB. DIAPRIDE (GLIMEPIRIDE)	2 MG	1	0	0	ORAL	BEFORE FOOD	TO CONTINUE
6	TAB. ISTAVEL D (DAPAGLIFLOZIN + SITAGLIPTIN)	10/100 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
7	TAB. Q REPA (REPAGLINIDE)	1 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
8	TAB. VGTRIO (METFORMIN, GLIMEPRIDE & VOGLIBOSE)	2 MG	1	0	1	ORAL	BEFORE FOOD	TO CONTINUE
9	TAB. NULONG (CILNIDIPINE)	10 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
10	TAB. NITROLONG (NITROGLYCERIN)	6.4 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
11	TAB. CARVIDON – MR (TRIMETAZIDINE)	60 MG	0	0	1	ORAL	AFTER FOOD	TO CONTINUE

DISCHARGE ADVICE

DIET	LOW FAT, SALT & DIABETIC DIET.
PHYSICAL ACTIVITIES	AVOID STRENUOUS ACTIVITIES.
REVIEW	REVIEW WITH DR. ANBARASU MOHANRAJ

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

Dr. K. JAISHANKAR

Reg. No: 49448

Typed by : Ezhilarasi.

CONSULTANT SIGNATURE

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

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

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PATIENT
HELPLINE
94557 94557
1800 572 3003

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Medway Centre of Excellence (Chennai)

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

MHI/HOSP/2022/118

DAY CARE INITIAL ASSESSMENT FORM

Date: 9/1/24 Time of arrival: 12:43

Part A (to be filled by Nurses)

Vital Signs: Temp: 98.5 (°F) | Pulse / HR: 73b/min (beats/min) | BP: 152/83 (mmHg)
Respiration: 24 (breaths/min) | SpO₂: 92 (%) | Height: 165 (cms) | Weight: 63.2 (kgs) | BMI: 23.2

Any Language Barrier: ☐ Yes ☒ No If yes, please call Language Coordinator / Translator

Allergies: ☐ Yes ☒ No If Yes, specify: _____

Psychosocial Assessment:

Alcohol Intake: ☐ Yes ☒ No **Substance Abuse:** ☐ Yes ☒ No **Smoking:** ☐ Yes ☒ No

Do you have any special religious, spiritual or cultural needs to be considered? ☐ Yes ☒ No

If Yes, specify details: _____

Pain Screening

Pain: ☐ Yes ☒ No. If Yes, Score: 0/10

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 (Age more than 12 years)

Duration: _____ **Location:** _____

Pain Character: ☐ Dull ☐ Aching ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Referred / Radiant Pain

Nutritional Screening:

Last 3 months Appetite ☐ Increased ☐ Decreased ☒ No Change

Last 3 months Weight ☐ Increased ☐ Decreased ☒ No Change

Fall Risk Screening for adults:

☐ No Risk

☐ Age more than 65 years

☐ History of fall in last 3 months

☐ Walks with assistance

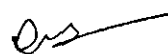
☐ Any neurological problem

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	Name	Emp. No.	Date	Time
Nurse		S. UMA MAHADEVAN	6208	9/1/24	12:55

Part B (to be filled by Physicians)**Chief Complaints**

Chest Pain.

Past Medical History

S/P CABG - & DUD.

Personal History

—

Significant Family History

—

Current Medication

S. No.	Current Medication	Dose	Route	Frequency	Date & Time of last dose	To be continued during hospital stay
	F. Dacel	500	po	0-0-0-1	8/1/24 at 8pm	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. Tadalafil	20	po	1-0-0-0	9/1/24 at 8am	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. Aspirin HT	80	P/O	1-0-0-0	9/1/24 at 8am	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. Zyrtec	10	P/O	0-0-0-1	8/1/24 at 8pm	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. Keppra		P/O	0-0-0-1	8/1/24 at 8pm	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. Robax HTS		P/O	1-1-0-1	8/1/24 at 8pm	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. Hydrocodone 2mg		P/O	1-0-0-1	8/1/24 at 8pm	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. Lisin		P/O	1-0-0-0	8/1/24 at 8am	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	T. Hydrocortisone. Nalox.		P/O	1-0-0-1	8/1/24 at 8am	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

CB4- 129

Clinical Examination / Investigation

Ureter - 30
Proximal - 1.2

Provisional Diagnosis

Chol pain F/G

Plan of Care (including Investigations Ordered)

C BG.

Doctor's Signature



Name DR. B. B. D. S. I.

Reg. No. (73) 12

Date

8/1/20

Time

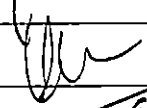

12-15



DOCTOR'S PROGRESS NOTES

DATE	NOTES
9/1/24	<u>CAG</u> (CAG no. 35-13)
15:45	- Rt. Radial access
	- SF sheath
	- SF TIA → CAG done
	LMCA - (N) Bifurcates into LAD & LCx
	Type 3 vessel
	LAD - Prox LAD has mild irregularities
	Mid LAD has 80% tubular stenosis - Distal LAD (N)
	Given 4 diagonal & many septals
	D ₁ is major diagonal, has mild irregularities
	D ₂ ^{is a small vessel} is a small vessel has significant ostial disease
	LCx - Non dominant. Prox LCx ^{is (N)} also major vessel
	Distal LCx is thin vessel & mild irregularities - Given 3 OM's
	OM ₁ & OM ₃ are major vessels
	OM ₁ is an early & major vessel, proximal part has 80% tubular stenosis
	OM ₃ is distally diseased
	RCA - Dominant. Prox RCA RCA has mild irregularities
	- Mid RCA has total occlusion. Distal RCA, PDA & PCx visualised
	By Gr II homo & heterocollaterals -
	LIMA - (N)
	Imp - Rt dominant / TVD
	Adv: CABG (Grafts to - LAD, Major OM & PDA/PCx)

[Signature]
9/1/24

DATE	NOTES
<div data-bbox="89 266 292 436" data-label="Text"> <p>9/1/24 16:00</p> </div>	<div data-bbox="592 223 1169 351" data-label="Text"> <p>q/a/R: Dr. G. Alston</p> </div> <div data-bbox="519 329 1461 436" data-label="Text"> <p>Can descend from Cath lab</p> </div>
	<div data-bbox="560 489 868 553" data-label="Text"> <p>COH = 2nd</p> </div> <div data-bbox="609 585 974 670" data-label="Text"> <p>high stable</p> </div>
	<div data-bbox="552 712 1055 989" data-label="Text"> <p>Phases: CABG Circ of m...  9/1/24</p> </div>
<div data-bbox="121 1117 324 1244" data-label="Text"> <p>9/1/24 16:30</p> </div>	<div data-bbox="462 1074 1307 1244" data-label="Text"> <p>pt - Can be discharged today.</p> </div>
	<div data-bbox="730 1212 1088 1436" data-label="Text"> <p> 9/1/24</p> </div>

Department of Dietetics.

NUTRITION ASSESSMENT AND CARE PLAN FORM

Patient Details (Affix Label here)
Name: Mr. Senthil
UHID: 202481705
DOB: 59Y Sex: M
DOA: 9/11/24
Consultant: Dr. Jishan Das

Diagnosis: CAD / T2DM / SHCN / CAD - DVD (2018) / EF - 38%
Height: 165 cms Weight: 63.2 Kgs Food allergies: Yes/No, If yes, specify.....
Religious Beliefs: ☐ Vegetarian ☒ Non Vegetarian ☐ Eggetarian ☐ Jain
Diet Prescription: 1600 calories, low fat, low salt, 1500ml fluid restricted

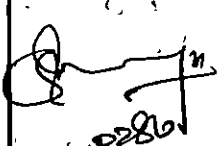
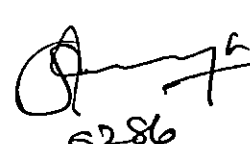
SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

diabetic diet

(A) Patient's related Medical History				
1) Weight Change (overall change in past 6 months)				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
No weight change/gain	<5%	5 - 10%	10 - 15%	>15%
2) Dietary Intake Duration:				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Oral	No change	Sub-optimal solid diet	Full liquid diet/moderate overall decrease	Hypo-caloric liquid diet
Enteral / Parenteral Nutrition	Adequate / Excessive	Sub-optimal	Inadequate	Typo-caloric feeds
3) Gastrointestinal Symptoms Duration:				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
No symptoms	Nausea	Vomiting / moderate GI symptoms	Diarrhoea	severe anorexia
4) Functional Capacity (Nutrition related functional impairment) Duration:				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
None / Improved	Difficulty with ambulation	Difficulty with normal activity	Light activity	Bed / chair-ridden with no or little activity
5) Co-morbidity (Disease and its relationship to nutrition requirements)				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input checked="" type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Healthy	Mild co-morbidity	Moderate co-morbidity / age >75 years	severe co-morbidity	Very severe multiple co-morbidity
(B) Physical examination				
1) Decreased fat stores or loss of subcutaneous fat				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Normal	Mild	Moderate		Severe
2) Sign of muscle wasting				
<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Normal	Mild	Moderate		Severe
Total Score = Sum of above 7 components				
Nutritional Status : Based on this patient is				
Well Nourished		<input checked="" type="checkbox"/> (7 to 14)		
Moderately Malnourished		<input type="checkbox"/> (15 to 18)		
Severely Malnourished		<input type="checkbox"/> (19 to 35)		
Nutrition Intervention:				
<input checked="" type="checkbox"/> Oral		<input type="checkbox"/> Enteral <input type="checkbox"/> Parenteral		
Diet counselling provided:		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Frequency of re-assessment:		<input checked="" type="checkbox"/> Weekly <input type="checkbox"/> Fort - night <input type="checkbox"/> Monthly		
Enteral / Parenteral		Calorie count: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

Dietitian Signature / Name / Date / Time:

9/11/24 10:00

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
5/11/24 10:00	<p>A 59 years old gentleman came to the breathlessness was assessed to be well- nourished as evident by S.M.</p> <p>K/G/O - T2DM / S.H. on patient shifted catheter for procedure (CABG) - kept on NBM - patient <u>reined</u> to Radial lounge - NBM over patient tolerated diabetic liquid diet can intake diabetic Soft Solid diets</p>	 6286
5/11/24 16:00	<p>Educated the patient & family on 1600 calories, low fat, low salt, 1500ml fluid restricted, diabetic diet on <u>discharge</u></p> <p>Emphasized on small frequent meals.</p> <p>Diet modifications & clarifications done.</p> <p><u>Diet chart given on discharge</u></p>	 6286



PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: CAD 11/2/18; Ischemic heart disease / Dr. P. Type II DM, SH-TN Moderate-LV Dys
Allergies if any: NKDA

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
<u>ICU</u>	<u>Cath Lab</u>	<u>11/24</u>	<u>14:05</u>	<u>CORONARY ANGIOGRAM</u>

Method of Transfer: ☐ On Bed ☒ On Wheelchair ☐ On Stretcher

ASSESSMENT OF PATIENT:

General condition of Patient: ☒ Conscious ☐ Semi-conscious ☐ Un-conscious

Language Barrier: ☐ Yes ☒ No ☐ If Yes, specify: _____

Fall Risk Category: ☒ Low Risk ☐ Medium Risk ☐ High Risk

Vital Signs (to be documented at the time of shifting):

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
<u>98.2</u>	<u>22</u>	<u>73 b/min</u>	<u>97</u>	<u>152/63</u>	<u>0/10</u>

Pain Scale used: ☐ PIPPS (28 weeks to ≤ 38 weeks) ☐ CRIES (38 weeks - 2 months)
☐ FLACC Scale (2 months - 7 years) ☐ Wong-Baker FACES Pain Rating Scale (7 years - 12 years)
☒ Numerical Rating Scale (> 12 years) ☐ CPOT (ventilator / comatose)

Any pre-medication given: _____

Any critical information: _____

Any specific recommendation: _____

Handover by	Signature	Name	Emp. No.	Date	Time
	<u>[Signature]</u>	<u>S. UMA MAHESWARI</u>	<u>0208</u>	<u>9/1/24</u>	<u>14:10</u>
Handed over to		<u>Sathya</u>	<u>0016</u>	<u>9/1/24</u>	<u>14:15</u>

After Procedure:

Procedure completed: ☒ Yes ☐ No | Any critical information: Nil

Vital Signs (to be documented at the time of shifting):

Temp (°F)	RR (breaths/min)	Pulse (beats/min)	SpO ₂ (%)	BP (mmHg)	Pain Score
<u>98.6 F</u>	<u>20 b/min</u>	<u>86</u>	<u>100</u>	<u>180/73 (108)</u>	<u>1/10</u>

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)

Handover by	Signature	Name	Emp. No.	Date	Time
	<u>[Signature]</u>	<u>Sathya</u>	<u>0016</u>	<u>9/1/24</u>	<u>16:10</u>
Handed over to		<u>[Signature]</u>	<u>0016</u>	<u>9/1/24</u>	<u>16:10</u>

Mr. SETHIL KUMARAN.P

59/Male/MHI202481705

09/01/2024/IPH2024000075

Dr. K. JAISHANKAR



CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

CONDITION AND PROCEDURE

Dr. K. JAISHANKAR 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 blood. 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:


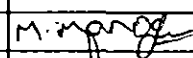

Less than 1 in 10,000 (0.0001%)	(a) skin injury from radiation, causing, reddening of the skin
1 in 1000 people (0.001%)	(b) A stroke. This can cause paralysis and long term disability (c) Heart attack. (d) A dangerous reaction to the x-ray contrast medium (dye). If this happens, you may have severe 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 puncture site
Most People	(n) Minor bruising

PATIENT CONSENT:

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

On the basis of the above statements,

I REQUEST TO HAVE THE PROCEDURE

	Signature	Name	Date	Time
Patient/Guardian with relationship		MR. SETHIL KUMARAN.P	9/1/24	13.30
witness		M. MANOJ	9/1/24	13.30
Doctor		Dr. Sathya Sudhan	9/1/24	13.30
Interpreter				

Patient Details (Affix Label here)

Name:

UHID:

DOB:

Sex:

இருதய ஆன்ஜியோகிராம் பரிசோதனைக்கான ஒப்பம்

நிலை மற்றும் செயல்முறை

பின்வரும் சூழ்நிலையை நான் கொண்டிருப்பதாக மருத்துவர் அவர்கள் விளக்கினார்.
பழைய இரும்புக் குழாய்களில் துருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாரடைப்பினை ஏற்படுத்துகிறது. இதயத்திற்கு ரத்தத்தினை வழங்கும் ரத்தக்குழாயான இதயச்சுவர் சிறை தமனிகளில் நோயின் அளவினை கண்டறிய கரோனரி ஆஞ்சியோகிராஃபி செயல்முறை மேற்கொள்ளப்படும். ஒரு லோக்கல் அனஸ்தீட்டிக் (மயக்க மருந்து) வழங்கப்பட்ட பின், ஒரு சிறிய குழாயானது (கத்தீடர்) கவட்டை/கையினுள்ள தமனியில் செலுத்தப்படும். இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிறை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின் கொண்டுள்ள கான்ட்ராஸ்ட் மீடியத்தினை (எண்ஸ்ரே டைட்) பயன்படுத்தி, பல வீடியோ படங்கள் வரிசையாக எடுக்கப்படும். இதயத்தின் முக்கிய ஏற்றியிறைத்தல் அறையில் (இடதுபக்க இருதய கீழறை) இந்த கான்ட்ராஸ்ட் மீடியம் உட்செலுத்தப்படலாம். இது இதயத்தின் அளவினை மதிப்பிடவும் மற்றும் அது எவ்வாறு பம்பு செய்கிறது என்பதை மதிப்பிடவும் மேற்கொள்ளப்படும். இப்பயங்கள் நமக்கு இதயச்சுவர்சிறை தமனிகள் குறித்த ஒரு படத்தினை வழங்கும். இது உங்களுக்கு ஏதேனும் அடைப்பு இருக்கிறதா என்பதை கண்டறிய உதவும். பின்னர் உங்கள் படங்களை கவனமாக பார்த்த பின் மருத்துவரால் உங்களுக்கு ஏற்ற சிகிச்சையை மேற்கொள்ள முடியும். இவை பை-பாஸ் அறுவை சிகிச்சையாகவும் இருக்கலாம் அல்லது ஆன்ஜியோபிளாஸ்டி (புனான் வடிவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

கிச்செயல்முறையிலுள்ள இடப்பாடுகள்

இதயச்சுவர் சிறை ஆன்ஜியோகிராஃபியிலுள்ள இடப்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

(i) இதயச்சுவர் சிறை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள சில தீவிர இடப்பாடுகள் நின்றவருமாறு. ஆனால் கிடைக்காத மட்டுமே முழுமையான இடப்பாடுகள் அல்ல

10.00-ல் ஒருவருக்கும் கீழ் (0.0001 சதவிகிதம்)	(a) கதிர்வீச்சின் காரணமாக ஏற்படும் தோல் பாதிப்பு, சருமம் சிவந்து போதல்
1000-ல் ஒருவருக்கு (0.001 சதவிகிதம்)	(b) வலிப்பு, இது பக்கவாதம் மற்றும் நீண்டநாள் ஊனத்தை ஏற்படுத்தலாம் (c) மாரடைப்பு (d) எக்ஸ்-ரே கான்ட்ராஸ்ட் மீடியத்தின் (டைட்) ஆபத்தான விளைவுகள் . இவை ஏற்பட்டால் உங்களுக்கு ஆஸ்துமா, அதிர்ச்சி மற்றும் வலிப்பு போன்றவைகள் ஏற்படலாம். 2,50,000 முதல் 4,00,000 ஊசிகளில் ஒன்று மரணத்தையும் விளைவிக்கலாம். (e) குத்தப்பட்ட இடத்தில் பெரிய அறுவை சிகிச்சை மேற்கொள்ள வேண்டியது வரலாம். (f) அவசரகால இதய அறுவை சிகிச்சை அல்லது ஆன்ஜியோபிளாஸ்டிக் தேவைப்படலாம். (g) எக்ஸ்ரே கதிர் பாதிப்பு காரணமாக அதிக வாழ்நாள் அச்சுறுத்தல் இடப்பாடு. (h) இறப்பு
100-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(i) இதயம் சரியான முறையில் துடிக்காமல் இருக்கலாம். அதற்கு அவசரமாக சிகிச்சை தேவைப்படும் (j) குத்தப்பட்ட கவட்டை பகுதியில் அறுவை சிகிச்சை சரிபாடு. இதனால் மருத்துவமனையில் நீண்ட நாட்கள் தங்கியிருக்க வேண்டியது வரலாம் (k) தோல் அரிப்பு போன்ற சிறு விளைவுகள் (l) கான்ட்ராஸ்ட் மீடியம் காரணமாக சிறுநீரகம் செயல்படாமை அல்லது அதன் வலு குறைதல்
20-ல் ஒருவருக்கு (0.01 சதவிகிதம்)	(m) குத்தப்பட்ட இடத்தில் பெரிய அளவினை சிராய்ப்பு அல்லது வீக்கம்
பெரும்பாலான மக்களுக்கு	(n) சிறிய அளவினை சிராய்ப்பு

நோயாளி ஒப்புதல்

மருத்துவர் அவர்கள் என்னுடைய மருத்துவ நிலையையும் மற்றும் முன்மொழியப்பட்டுள்ள செயல்முறையையும் எனக்கு விளக்கினார். செயல்முறையிலுள்ள இடப்பாடுகள், மயக்க மருந்துகள் உட்பட எனக்கு குறிப்பாக ஏற்படும் இடப்பாடுகள் மற்றும் சிக்கல்கள் ஏற்பட்டால் என்னவாகும் என்பவைகளை நான் புரிந்து கொண்டள்ளேன். மருத்துவர் பிற தொடர்புள்ள சிகிச்சை விருப்பத் தேர்வுகள், அதன் இடப்பாடுகள் மற்றும் சிகிச்சை மறுப்பதற்கான என்னுடைய உரிமை ஆகியவைகளையும் எனக்கு விளக்கினார். அதன் தொற்றின்மை மற்றும் ஒருமைப்பாடு உறுதிசெய்யப்பட்டவுடன் சில மறு செயலாக்கப்பட்ட பொருட்கள் பயன்படுத்தப்படலாம் என்று எனக்கு விளக்கப்பட்டுள்ளது. அவர் என்னுடைய முன் கணிப்புகள் மற்றும் செயல்முறையை மேற்கொள்ளாமல் இருப்பதால் ஏற்பட வாய்ப்புள்ள இடப்பாடுகள் ஆகியவைகளையும் எனக்கு விளக்கினார். என்னுடைய நிலை குறித்து என்னால் கேள்வி எழுப்ப முடிந்தது மற்றும் என்னுடைய கவலைகளை தெரிவிக்கவும், செயல்முறை மற்றும் அதன் பலன்களை தெரிவிக்கவும் மற்றும் எனது சிகிச்சை விருப்பத்தேர்வுகள் குறித்த கவலைகளையும் என்னால் தெரிவிக்க முடிந்தது. என்னுடைய கேள்விகளும் மற்றும் கவலைகளும் கலந்தாலோசிக்கப்பட்டது மற்றும் எனக்கு திருப்திகரமான முறையில் அவற்றிற்கு பதிலளிக்கப்பட்டது. அசாதாரணமான சூழலில், எனக்கு இரத்தமேற்றாதல், ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகிச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டுள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகிச்சையளிக்கப்படும் என்பதை எனக்கு விளக்கினார். கிச்செயல்முறையினால் என்னுடைய நிலை மேம்படும் என்பதற்கு எத்தகைய உத்தரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டுள்ளேன்.

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

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



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CORONARY ANGIOGRAM REPORT

PATIENT NAME : Mr. SENTHIL KUMARAN. P
AGE/GENDER : 59 YEARS / MALE
CONSULTANT : Dr. Jaishankar. K MD., DM., FIAMS
 Director and Clinical Lead
 Cardiology and Electrophysiology

UHID : MHI202481705
IP NO : IPH2024000075
D.O.A : 09.01.2024
D.O.P : 09.01.2024

CATH DATE	09.01.2024	DONE BY	DR. JAISHANKAR
CATH NO	3573	ASSISTED BY	SN. SATHYA
CATH DURATION	5 MINS	TECHNICIAN	MR. TAMIL
HEIGHT WEIGHT	165CMS 63KGS	PHYSICIAN ASSISTANT	MS. SHALINI

CLINICAL DIAGNOSIS: CAG –DOUBLE VESSEL DISEASE (11.2.2018, KALYAAN HOSPITAL), MODERATE LV DYSFUNCTION, SYSTEMIC HYPERTENSION, TYPE II DIABETES MELLITUS

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

APPROACH : RIGHT RADIAL ARTERY

SHEATH : 5FR

CATHETER : 5FR TIG

CONTRAST MATERIAL: NON- IONIC, VISIPAQUE

MEDICATIONS : Inj. Heparin 2500 IU

COMMENTS:

LMCA - NORMAL. BIFURCATES INTO LAD AND LCX.

LAD - TYPE III VESSEL AND GIVES RISE TO 4 DIAGONALS AND MANY SEPTALS. PROXIMAL LAD HAS LUMINAL IRREGULARITIES. MID LAD HAS 80% TUBULAR STENOSIS. DISTAL LAD APPEARS NORMAL. D1 IS A MAJOR DIAGONAL, HAS LUMINAL IRREGULARITIES. D2 IS A SMALL VESSEL WITH SIGNIFICANT OSTIAL DISEASE.

LCX - NON-DOMINANT AND GIVES RISE TO 3 OMS. OM 1 & OM 3 ARE MAJOR VESSELS. PROXIMAL LCX APPEARS NORMAL. DISTAL LCX IS A THIN VESSEL WITH LUMINAL IRREGULARITIES. OM 1 IS AN EARLY AND MAJOR VESSEL, PROXIMAL PART HAS 80% TUBULAR STENOSIS. OM3 IS DIFFUSELY DISEASED.

RCA - DOMINANT AND GIVES RISE TO PDA AND PLV BRANCHES. PROXIMAL RCA HAS LUMINAL IRREGULARITIES. MID RCA HAS TOTAL OCCLUSION. DISTAL RCA, PDA & PLV VISUALISED BY GRADE II HOMO & HETEROCOLLATERALS.

LIMA-NORMAL

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

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**PATIENT
HELPLINE**

94557 94557
1800 572 3003

Medway Group of Hospitals

Medway Centre of Excellence (Chennai)

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

MHI/HOSP/2022/118



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IMPRESSION:

TRIPLE VESSEL DISEASE
MODERATE LV DYSFUNCTION
RIGHT DOMINANT SYSTEM

ADVICE:

CABG (GRAFTS TO LAD, MAJOR OM & PDA/PLV)

for

CONSULTANT SIGNATURE

for

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

To visit at www.medwayhospitals.com

Dr. K. JAISHANKAR
Reg. No: 49448

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

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Heart Institute 044 - 4310 8959	Institute of Pulmonology 044-2473 4451
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E-mail : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

MHI/HOSP/2022/118



DATE & TIME	Observation / Action	Signature with Emp.No
9/1/24 12:45	<p>→ pt got admission to RL pt is conscious & oriented pt vitals stable</p> <p>→ pt consent taken</p> <p>→ pt NPO @ 10:00 am.</p> <p>→ pt history collected</p> <p>→ pt Ht & Wt checked</p> <p>→ pt shifted to cath lab @</p>	<p><i>[Signature]</i> 0206</p> <p><i>[Signature]</i> 0206</p>
14:15	<p><u>Cath lab report</u></p> <p>Patient received from RL to cath lab. conscious & oriented vitals stable. IV line on left hand 20G venflon. patient V/P score is 0/5.</p>	<p><i>[Signature]</i> 0206</p>
15:15	sterile drapping done. Procedure through the right radial approach under local anaesthesia.	<p><i>[Signature]</i> 0206</p>
15:25	During procedure Inj. Heparin 2500 given IV o/b DR. TS Sir	<p><i>[Signature]</i> 0206</p>
15:30	HR = 88 bpm, BP = 181/70 (107) mmHg, SPO ₂ = 100%	<p><i>[Signature]</i> 0206</p>
15:35	CAG done successfully. Right radial arterial sheath removed. No oozing & hematoma. Plaster bandage applied over the Cath site	<p><i>[Signature]</i> 0206</p>
	Patient shifted to RL & all reports handed over	<p><i>[Signature]</i> 0206</p>
Document endorsed by	Signature	Name
	<i>[Signature]</i>	Bathiya
		Emp. No.
		0206
		Date
		9/1/24
		Time
		15:45

DATE & TIME	Observation / Action	Signature with Emp.No
16.10	Patient shifted to CCU with all documents. pt handing over to ccu smethn. procedure side no oostg. oosth.	[Signature]
16.15.	patient received from CCU @ 16.15. Pt conscious and oriented pt (P.D) Pade Appered Pt No oozy. Cnd No haematoma Vitals Stable.	[Signature]
16.20	⇒ pt Royal intake juce. ⇒ pt was AD Clinician.	[Signature]
18.15	⇒ pt got discharge Pt Vitals Stable. Jy hand and Wound removed. Pt got discharge file hand over file TO PH Attended.	[Signature]

Document endorsed by	Signature	Name	Emp. No.	Date	Time
	Jeev	JAYARAJ	000	9/1/24	19-00

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

Mr. SENTHIL KUMARAN.P
59/Male/MHI202481705
09/01/2024/IPH2024000075
Dr. K. JAISHANKAR

MHI/OT/2022/086

Name of the Procedure : CAG Location : Cath lab Date & Time : 9/1/24

PATIENT LABEL

Does the Procedure involve Procedural Sedation : ☐ Yes ☒ No

SIGN IN <u>15-15</u> Before Induction of Procedural Sedation		TIME OUT <u>15-25</u> After procedural Sedation and before procedure		SIGN OUT <u>15-40</u> When Doctor Indicates that the Procedure is completed	
(Anaesthetist / Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the procedure)		(Anaesthetist or Qualified Physician administering Procedural Sedation + Nurse + Technician + Doctor performing the Procedure)			
Patient Confirmation		All team members introduce themselves by Name and Role		To be done for each procedure in case of multiple procedures	
Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Identity by two identifiers	<input checked="" type="checkbox"/> Yes	Name of the Procedure done written down <u>CAG</u> <input checked="" type="checkbox"/> Yes	
Procedure	<input checked="" type="checkbox"/> Yes	Procedures	<input checked="" type="checkbox"/> Yes	Name and site of all specimens / investigations / <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	
Side	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	Side	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	confirms labeling and sent to lab	
Consent	<input checked="" type="checkbox"/> Yes	Position	<input checked="" type="checkbox"/> Yes	Any recovery concerns : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
Known Allergy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please specify	Consent	<input checked="" type="checkbox"/> Yes	If Yes, Pls. specify :	
		Required equipment and implants available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
Difficult airway / aspiration risk / dentures	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, equipment and assistance available	Essential Imaging displayed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
Possibility of hypothermia	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, warmer in place	Antibiotic prophylaxis within last 60 minutes	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Name of the Antibiotic given		Any Equipment / instrument problem that needs to be addressed : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> None	
		Venous Thromboembolism Prophylaxis Provided	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	If Yes, Pls. specify :	
All concerned anesthesia equipment and medication check complete		Anticipated duration briefed	<input checked="" type="checkbox"/> Yes		
<input type="checkbox"/> SpO2 <input type="checkbox"/> NIBP <input type="checkbox"/> Others pls. specify <u>EKG</u>		Anticipated blood loss briefed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
Pre OP medication taken	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Adequate fluids and blood available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA		
		Team briefed on any critical or unexpected steps	<input checked="" type="checkbox"/> Yes	Corrective action :	
Required equipment for procedure available	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> NA	For procedural sedation cases			
		Any patient specific concerns :	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
		Intra procedure glyceric control	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
		Any concerns about sterility	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> None		
Anaesthetist / Doctor giving Procedural Sedation	Doctor performing the Procedure :	Nurse :	Technician :	Others Please Specify :	
Date : <u>9/1/24</u> Time : <u>15.50</u>	Date : <u>9/1/24</u> Time : <u>15.50</u>	Date : <u>9/1/24</u> Time : <u>15.50</u>	Date : <u>9/1/24</u> Time : <u>15.50</u>	Date : <u>9/1/24</u> Time : <u>15.50</u>	


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Medway Heart Institute

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Procedure Monitoring Sheet (Cath Lab)

 Patient Name : **Mr. SENTHIL KUMARAN.P**
 59 / Male / MHI202481705

UHID / IP : 09/01/2024 / IPH2024000075

Consultant : Dr. K. JAISHANKAR

Age / Sex : 57 / M

Ward Unit : R

 Diagnosis : **CAD 11/12/22 KALYAN HOSPITAL**
TYPE II DM, SAPHY PROSTATE LV
DYSLIPIDEMIA NEDA

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

PARAMETERS	YES	NO	NA
Vital signs : BP: 150/95 Temp: 98.2 Pulse: 73 RR: 22 SPO2: 98%	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine voided	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel preparation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pre-procedure medication administered	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Procedure site marked	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin preparation done	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NPO <input checked="" type="checkbox"/> 6:00 AM	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loose Tooth removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact lenses / Eye glasses removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prosthesis present	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Jewellery/Nail polish removed	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Checked for Allergies (Drug / food)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
IV line/In-situ	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consent taken	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Investigation reports / Documents received	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Signature of Nurse : <i>[Signature]</i>	Date & Time : 9/1/24 @ 12:55		

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

Time	HR / min	RR / min	BP mmHg	SpO2%	Medication / Remarks	Sign of Nurse
15:25	86 b/min	20 b/min	170/90 (114)	98.1	—	<i>[Signature]</i>
15:25	88 b/min	20 b/min	169/87 (112)	98.1	—	<i>[Signature]</i>
15:35	88 b/min	20 b/min	190/75 (114)	98.1	—	<i>[Signature]</i>
Procedure got over						

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

Time : 15:45 Route : Right radial approach
 Complication : Nil

BP : 180/71/108 mmHg, HR : 78 b/m, RR : 20 b/m SpO2 : 100%
Brachial Distal Pulse : Felt, Puncture Site : No oozing & haematoma

Advise:

- ◆ Shift To: Ward / ICU 6 hours
- ◆ Bed rest up to _____ hours
- ◆ Observe puncture site for bleeding
- ◆ Watch for Pulse in Radial artery.
- ◆ Diet

◆ Inform Duty Medical Officer SOS

- a) If patient complains of any Discomfort
- b) If dressing is Loose or Socked with Blood
- c) If limbs are Cold / Absent Pulse

- ◆ Remove Radial arterial dressing on 10/1/24 at 16-00 AM /PM after informing to the consultant.

- ◆ Special instruction if any:

Nil

[Signature]
 9120
 Name & Signature of Consultant

POST PROCEDURE OBSERVATION

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse
<u>9/1/24</u> <u>15:50</u>	<u>180/10</u>	<u>78</u>	<u>20</u>	<u>100%</u>	<u>Right Radial artery approach</u>	<u>No oozing</u>	<u>-</u>	<u>[Signature]</u>

Nurses Notes :

Right radial arterial sheath removed. No oozing & haematoma. Plaster bandage applied over the cath site

Condition at the end of procedure : ☒ Stable ☐ Critical

Patient shift to : ☐ Recovery Room ☐ Patient Room ☒ CCU ☐ Other ICU

Name & Signature of the Nurse : [Signature]

Date & Time : 9/1/24 16:10

BRADEN SCALE FOR PREDICTING PRESSURE INJURY RISK

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	3	3		
ACTIVITY degree of physical activity	1. Bedfast Confined to bed	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours	3	3		
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	3. Slight Limited Makes frequent through slight changes in body or extremity position independently	4. No Limitation Makes major and frequent changes in position without assistance	3	3		
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy 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, dairy 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 dairy products. Occasionally eats between meals. Does not require supplementation	3	3		
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent re-positioning with maximum 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		3	3		
					TOTAL SCORE	14	64	
					Initial & Emp. No. of Staff Nurse:	22	02	
					Initial & Emp. No. of Sr. Staff Nurse:	11	02	

Score Interpretation: Minimal Risk: 23 - 19; At Risk / Mild Risk: 18 - 15; Moderate Risk: 14 - 13; High Risk: 12 - 10; Severe Risk: 9 - 6

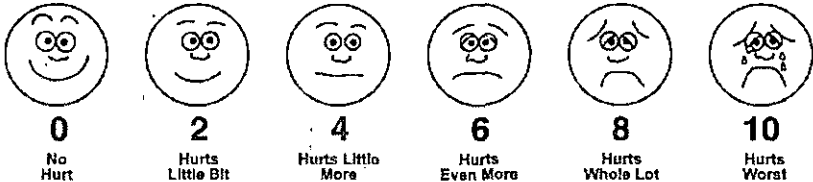
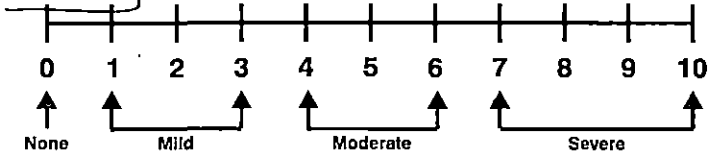


PAIN RE-ASSESSMENT & MONITORING CHART

Date & Time	Pain Score	Pain Character (dull, achy, sharp, stabbing, shooting, burning, referred / radiant pain)	Duration	Location / Site	Interventions	Staff Initial & Emp. No.	Senior Staff Initial & Emp. No.
5/1/24 12:43	0/10	No pain	—	—	—	Dr. Jaishankar	Dr. Jaishankar
		PATIENT		RECOVERED FROM CATH LAB @ 16:10.			
16:10	0/10	No pain	—	—	—	Dr. Jaishankar	Dr. Jaishankar
17:00	0/10	No pain	—	—	—	Dr. Jaishankar	Dr. Jaishankar
18:00	0/10	No pain	—	—	—	Dr. Jaishankar	Dr. Jaishankar
		PATIENT		Got Discharge @ 18:20			

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.

PAIN SCALES



PIPPS (28 weeks to \leq 38 weeks)	6 or less = Minimal to no pain 7 - 12 = Mild pain - Provide comfort measures >12 = Moderate to severe pain - Pharmacological intervention					
CRIES (38 weeks - 2 months)	The CRIES scale is used for infants > than or = 38 weeks of gestation. A maximal score of 10 is possible. If the CRIES score is > 4, further pain assessment should be undertaken, and analgesic administration is indicated for a score of 6 or higher.					
FLACC Scale (2 months - 7 years)	0: Relaxed & comfortable, 1-3: Mild discomfort, 4-6: Moderate discomfort, 7-10: Severe discomfort / pain / both					
Wong-Baker FACES Pain Rating Scale (7 years - 12 years)						Numerical Rating Scale (age more than 12 years) 
Critical care Pain Observation Tool (CPOT) (ventilator / comatose)	FACIAL EXPRESSION: 0 - Relaxed, Neutral, 1 - Tense, 2 - Grimacing BODY MOVEMENTS: 0 - Absence of movements or normal position, 1 - Protection, 2 - Restlessness / Agitation COMPLIANCE WITH VENTILATION (intubated patients): 0 - Tolerating Ventilator or Movement, 1 - Coughing but tolerating, 2 - Fighting ventilator (or) VOCALIZATION (non-intubated patients): 0 - Talking on normal tone or no sound, 1 - Sighing, Moaning, 2 - Crying out, sobbing MUSCLE TENSION: 0 - Relaxed, 1 - Tense, Rigid, 2 - Very Tense, Rigid TOTAL SCORE: 0 - 2: No Pain; 3 - 4: Moderate Pain; 5 - 8: Severe Pain					
Non-pharmacological Interventions	Distraction: A - Relaxation-conducive environment; B - TV; C - Music; D - Physical and mental exercisers Cutaneous Stimulation and massage: E - Positioning; F - Rubbing / Massage the skin Thermal Therapies (no longer than 15 to 20 minutes): G - Cold application; H - Hot application; I - Shortwave diathermy Transcutaneous electrical nerve stimulation (TENS): J - Interferential therapy Psycho-social therapy/counselling: K - Individual Counseling; L - Family counseling					

Pharmacological Interventions as per doctor's prescription



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

000

MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date	9/1/24	9/1/24							
	Time	12:50	16:10							
History of falling (immediate or within 6 months)	No	0	0	0	0	0	0	0	0	0
	Yes	25	25	25	25	25	25	25	25	25
Secondary diagnosis (≥ 2 medical diagnosis)	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Intravenous Therapy / Heparin Lock / Tubes Insitu	No	0	0	0	0	0	0	0	0	0
	Yes	20	20	20	20	20	20	20	20	20
AMBULATORY AID										
None / Bed Rest / Nurse Assist		0	0	0	0	0	0	0	0	0
Crutches / Cane / Walker		15	15	15	15	15	15	15	15	15
Furniture		30	30	30	30	30	30	30	30	30
GAIT										
Normal / Bed Rest / Wheel Chair		0	0	0	0	0	0	0	0	0
Weak		10	10	10	10	10	10	10	10	10
Impaired		20	20	20	20	20	20	20	20	20
MENTAL STATUS										
Oriented to own stability		0	0	0	0	0	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, immunosuppressant, anticonvulsants, anti-hypertensives, hypoglycemics and psychotropics	No	0	0	0	0	0	0	0	0	0
	Yes	15	15	15	15	15	15	15	15	15
Total Score		50	50							
Low Risk (0 - 24)										
Medium Risk (25 - 44)										
High Risk (45 or above)										
Signature & Emp. No. of RN										
Signature & Emp. No. of Sr. RN										

0 - 24: Low Risk; 25 - 44: Medium Risk; 45 or above: High Risk

INTERVENTIONS <i>Tick as per the Risk Score</i>	Date																		
	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 call bell, bedside table, water, glasses within the patient's easy reach	/	/																	
Remove excess equipment or furniture to make a clear path	/	/																	
Keep the patient's bed in the low position at all times except during procedure	✓	/																	
Teach fall-prevention techniques, such as sitting up for a moment before rising from the bed	/	/																	
Bed wheels should be locked	/	/																	
Encourage family participation in the patient's care	/	/																	
Ensure that floor of the bathroom is dry and not slippery	/	/																	
Review medications for potential side effects that can promote falls	/	/																	
Use safety belts during movement in wheelchair	/	/																	
The patients are not ambulated by themselves. They are to be ambulated only with assistance	/	/																	
Medium risk interventions (25 - 44)																			
Apply all the low risk interventions	/	/																	
Tie yellow fall risk tag in the bed and Wheel chair / Stretcher	✓	/																	
Make sure that proper transfer precautions are instituted for heavy or debilitated patients in a bed or wheel chair or on a toilet seat	✓	/																	
Use restraints and bed monitors as ordered by the doctor	/	✓																	
Allow the patient to ambulate only with assistance	/	/																	
Consider peak effects of the medications that effects level of consciousness, gait and elimination when planning patient's care	✓	/																	
Do not leave patients unattended in diagnostic or treatment areas	✓	✓																	
Accompany the patient while going to bathroom	✓	/																	
Advise the patient to use grab bars near the toilet, bathtub, and shower	✓	/																	
Make sure the family and other visitors understand the restrictions mentioned above	/	✓																	
High-risk interventions (45 or above)																			
Apply all the low and medium risk interventions	/	✓																	
Tie red fall risk tag in the bed, wheel chair and stretcher	/	/																	
Locate the high-risk patients in a room close to the nurses' station	✓	/																	
Answer these patients call bells as quickly as possible	/	/																	
Provide a commode at bedside (if appropriate)	/	/																	
Urinal/bedpan should be within easy reach (if appropriate)	✓	/		</															