

MRD CHECKLIST

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


Medway Hospitals®

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

Mr. EMANUVEL R

52/Male/MHI202381541

28/12/2023/IPH2023002620

Dr. G. GNANAVELU



Where heart beat never stops...

ADMISSION SLIP

 Admitting Doctor: Dr. Gnanavelu Speciality: Cardiology

 Advised Date & Time: 28/12/23 @ 10:18 AM 10:50 PM

Provisional Diagnosis:

Type II DM / Chronic depression / SR / LV function
 +ve 7/12/23 +ve

 Reason for Admission: ☐ Medical Management ☐ Surgical Management
☒ Others (please specify details) _____

 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: Daycare

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

 Payee: ☒ Self ☐ Insurance ☐ Others: _____

Instructions to Nurse (if any):

Admission on ER

Any other Instructions (if any):

100000-

Doctor's Signature 	Name: <u>Dr. G. Gnanavelu</u> Designation: <u>Chief Cardiologist</u> Reg. No: <u>39469</u>	Reg. No.: <u>39469</u>	Date: <u>28/12/23</u>	Time: <u>10:18 AM</u>
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For admission desk staff only:

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

Admission intimation Receipt Details

Admission Time in HIS

Date

Time

Date

Time

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



ADMISSION FORM

Marital Status Single	Full Address R. EMANUVEL 962 Gnanapathy Nagar Kiliyapattu Post Tiruvannamalai. Dist.		Telephone Number 9789378749
Occupation CAD			
Referred from Dr. Gnanavelu	Date of Time of Admission 28/12/23 10:50 AM	Date & Time of Discharge 28/12/23 @ 18:30	Total No. of Days 7 hrs.
UNIT RL	MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes AR No. :		
FINAL DIAGNOSIS			ICD Code
Atypical Chest pain			R07.4
TM - POSITIVE (7.2023)			R04.3
NORMAL LV FUNCTION			I50.1
TYPE II DIABETES MELLITUS			E11.9
Dyslipidemia.			E78.5
DATE	OPERATION / PROCEDURES		ICPM Code
28/12/23	Coronary ANGIOGRAM.		88.50
DATE	TYPE OF ANESTHESIA		
28/12/23	<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 type="checkbox"/> Discharge at Request <input type="checkbox"/> Expired < 48 hours <input checked="" type="checkbox"/> Improved <input type="checkbox"/> Against Medical Advice <input type="checkbox"/> Expired > 48 hours <input type="checkbox"/> Unchanged <input type="checkbox"/> Absconded <input type="checkbox"/> Post-Operative Death <input type="checkbox"/> Transferred to			
Signature of the Consultant		Signature of Medical Records Officer	

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. R. E. M. N. V. E. L. who is my brother..... (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 their 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

தேதி

Date



எனது/உறவினர்/காப்பாளர் கையொப்பம்

Signature of the Patient / Relative / Gurdian

Brother.
உறவுமுறை

Nature of Relationship



GENERAL CONSENT FOR ADMISSION




I, R. EMANUEL. 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		R. EMANUEL.	28/12/23	10:50am
Surrogate/Guardian (if applicable #)		R. SOLOMONRAJA. (Write name and relationship with patient)	28/12/23	10:50am
Reason for surrogate consent	Patient is unable to give consent because:			
Witness		R. Thangasathi	28/12/23	11:30am
Interpreter (if applicable)				

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



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

DAY CARE DISCHARGE SUMMARY

IP No.	IPH2023002620	D.O.A	: 28/12/2023
UHID	MHI202381541	D.O.P	: 28/12/2023
Name	Mr. EMANUVEL.R	Room No.	: RL
Age / Gender	52Years / MALE		
Consultant	: Dr. G. Gnanavelu. MD., DM., (cardio) FACC Chief Cardiologist	D.O.D	: 28/12/2023

DIAGNOSIS:

ATYPICAL CHESTPAIN
TMT - POSITIVE (7.2023)
NORMAL LV FUNCTION
TYPE II DIABETES MELLITUS
DYSLIPIDEMIA

PROCEDURE: CORONARY ANGIOGRAM DONE ON 28.12.2023 – MINIMAL CORONARY ARTERY DISEASE.

BRIEF HISTORY:

Mr. Emanuvel.R, 52 years old male, presented with complaints of chest discomfort. He was advised Coronary angiogram and referred to Medway Heart Institute on 28.12.2023 for which he has been admitted.

ON EXAMINATION:

HR: 94bpm ; BP: 128/67mmHg ; SPO₂: 95% in room air
CVS: S1S2+ ; RS : Clear ; CNS: NFND; Abd: Soft

INVESTIGATIONS:

BLOOD: HB – 16.5gm/dl, TWBC – 10800cell/cumm, PLT – 134cells/cumm, Urea – 31.2mg/dl, Creatinine – 1.0mg/dl, Na+ - 138.8 meq/l, Na+ - 4.0 meq/l.

ECG: sinus rhythm, HR – 95bpm. Within normal limits

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

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94457 94457
1800 572 3003

Medway Group of Hospitals

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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 4454

MHI/HOSP/2022/118

CORONARY ANGIOGRAM FINDINGS:

Right -dominant system; **MINIMAL CORONARY ARTERY DISEASE.** (reports enclosed)

ADVICE : Medical management.

ADVICE MEDICATIONS:

SI. NO	NAME OF THE DRUGS WITH GENERIC NAME	DOSAGE	FREQUENCY			ROUTE	RELATION SHIP WITH FOOD	DURATION
			M	A	N			
1	TAB. ROZAVEL A (ASPIRIN AND ROSUVASTATIN)	75 MG	0	1	0	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. TIMZID MR	35 MG	1	0	1	ORAL	AFTER FOOD	TO CONTINUE
2	TAB. FOURTS B	1 TAB	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
3	TAB. DAPACOSE (DAPAGLIFLOZIN)	10 MG	1	0	0	ORAL	AFTER FOOD	TO CONTINUE
4	TAB. VOLIBO M (METFORMIN & VOGLIBOSE)	0.3/500 MG	1	1	1	ORAL	AFTER FOOD	TO CONTINUE

DISCHARGE ADVICE	
DIET	LOW FAT DIET.
PHYSICAL ACTIVITIES	AVOID STRENUOUS ACTIVITIES.
REVIEW	REVIEW WITH DR. G. GNANAVELU AFTER 1 WEEK.

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

Understood the Content of the discharge summary."

R. M.

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

G.

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

Typed by: Ezhilarasi.



DAY CARE INITIAL ASSESSMENT FORM

Date: 28/12/23 Time of arrival: 11:15 am

Part A (to be filled by Nurses)

Vital Signs: Temp: _____ (°F) | Pulse / HR: 94 (beats/min) | BP: 128/64 (mmHg)

Respiration: 18 (breaths/min) | SpO₂: 95 (%) | Height: 162 (cms) | Weight: 68 (kgs) | BMI: 25.4 kg/m²

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		<u>Madhumitha</u>	<u>0244</u>	<u>28/12/23</u>	<u>11:30</u>

Part B (to be filled by Physicians)

Chief Complaints

Chess Discomfort during match

Past Medical History

Personal History

Significant Family History

Current Medication

[illegible]

Clinical Examination / Investigation

CVS - S.S.

Respiratory

Abd - Soft

Gen - Normal

ESR - 131 mg/dL

Hb - 16.8

RR (A + ve)

Na - 138

K - 4.0

CRP 1.0

Urea - 31.2

Serology (WBC)

Provisional Diagnosis

DM/DLP / Chronic Depression / NDR / (N LUP)

7mf 2021 - +ve 7.5 mm

2022 - -ve 10.3 mm

2023 - +ve 7 mm

Plan of Care (including Investigations Ordered)

Refer to GP

Doctor's Signature

Name

Dr. Anish Nelson
Reg. No: 88434

Reg. No.

Dr. Anish Nelson
Reg. No: 88434

Date

28/12/23

Time

11.30



DOCTOR'S PROGRESS NOTES

DATE	NOTES
	<u>Dr. Nelson</u>
28/12/23 14:00	Byg <u>Radial artery</u>
	o - Minimal <u>cm</u>
	pen - <u>cm</u>
28/12/23 14:00	<u>close dilation (ca)</u>
	- PO <u>Measure</u>
	- HD <u>STAB</u>
	- COA - <u>MINIMAL</u> <u>cm</u>
	- PVR - <u>cm</u>
	<u>Dr. Nelson</u> Dr. Anish Nelson Reg. No. 88434
16:00 PM	<u>Produce</u> <u>cm</u> <u>at</u> <u>discharge</u>
	<u>Dr. Nelson</u> Dr. Anish Nelson Reg. No. 88434

Patient Details (Affix Label here)

Name: MR. Emmanuvel P
UHID: 20238154
DOB: 28/12/23 Sex: male
DOA: 28/12/23
Consultant: G. Granavelu

Department of Dietetics

NUTRITION ASSESSMENT AND CARE PLAN FORM

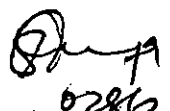
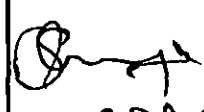
Diagnosis: <u>OAG / T2DM / Dyslipidemia</u>				
Height: <u>168</u> cms	Weight: <u>68</u> Kgs	Food allergies: Yes/No; if yes, specify.....		
Religious Beliefs:	<input type="checkbox"/> Vegetarian	<input checked="" type="checkbox"/> Non Vegetarian	<input type="checkbox"/> Eggetarian	<input type="checkbox"/> Jain
Diet Prescription: <u>1600 calories, low fat, low salt, diabetic diet</u>				

SUBJECTIVE GLOBAL ASSESSMENT (ADULTS)

(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
6) 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
Enteral/Parenteral		<input type="checkbox"/> Daily		Calorie count: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Dietitian Signature / Name / Date / Time:

G. Granavelu 16:00
0286 28/12/23

DATE AND TIME	DIETITIAN NOTES	SIGNATURE
<p>28/12/23 10:00</p>	<p>A 52 years old gentleman Came to C/O chest discomfort was assessed to be well- nourished as evident by SGA K/C/O - T2DM / dyslipidemia patient shifted to cath lab for procedure (CAG). Reptom NBM. Patient received to Radial lounge. NBM over. patient started diabetic liquid diet. can initiate diabetic soft solid diet. Educated the patient & family on 1600 calories, low fat, low salt, diabetic diet on <u>discharge</u>.</p>	<p> 0286</p>
<p>28/12/23 16:00</p>	<p>Emphasized on small frequent meals. <u>Diet chart</u> given on <u>discharge</u></p>	<p> 0286</p>

PATIENT TRANSFER FORM DIAGNOSTICS / PROCEDURES

Diagnosis: Dm, DM, PMS, T1D Allergies if any: UNKNOWN

From (Area)	To (Area)	Date	Time	Reason for Transfer / Name of Procedure
RL	Cath lab	28/12/23	13:30	CAC

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
97.2	20 b/min	88 b/min	96% RA	127/78 mmHg	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 (> 12 years) ☐ CPOT (ventilator / comatose)

Any pre-medication given: _____

Any critical information: _____

Any specific recommendation: _____

	Signature	Name	Emp. No.	Date	Time
Handover by		Maathumithy	0224	28/12/23	13:30
Handed over to		Prayas	0221	28/12/23	13:35



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
98.1 P	20 b/min	74 b/min	100%	127/85 mmHg	1/10

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	Name	Emp. No.	Date	Time
Handover by		Prayas	0221	28/12/23	14:20
Handed over to		Dr. S. S. S. S. S.	0221	28/12/23	14:20

CONSENT FOR CORONARY ANGIOGRAM / CORONARY ANGIOPLASTY

Mr. EMANUEL R		Sex: M/F	
Patient:	52/Male/MHI202381541 28/12/2023/IPH2023002620	Bed No:	UHID
Consu	Dr.G. GNANAVELU		

CONDI

Dr. G. GNANAVELU has explained 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:

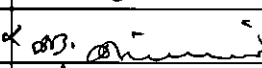
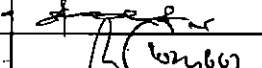

Less than 1 in 10,000 (0.0001%)	(a) skin injury from radiation, causing, reddening of the skin
1 in 1000 people (0.001%)	(b) A stroke. This can cause paralysis and long term disability (c) Heart attack. (d) A dangerous reaction to the x-ray contrast medium (dye). If this happens, you may have severe 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. G. GNANAVELU 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 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. Emanuel R	28/12/23	11.30
witness		R. Solomon Raja	28/12/23	11-30
Doctor		Dr. G. Gnanavelu	28/12/23	11.30
Interpreter				

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

நிலை மற்றும் செயல்முறை

பின்வரும் ஆழ்நிலையை நான் கொண்டிருப்பதாக மருத்துவர் அவர்கள் விளக்கினார்.

பழைய இருமட்கு குழாய்களில் துருபிடிப்பதைப் போல், தமனிகளில் கொழுப்பு மற்றும் கால்சியம் சேரும். இது ஆன்ஜினா அல்லது மாறடைப்பினை 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 (கத்தீட்டர்) கவட்டை/கையிலுள்ள தமனியில் செலுத்தப்படும், இந்த குழாய் ஒவ்வொரு இதயச்சுவர் சிறை தமனிகளிலும் மாற்றி மாற்றி கவனமாக வரிசையாக செலுத்தப்படும். எக்ஸ்ரே மற்றும் பிற அயோடின கொண்டுள்ள கான்ட்ராஸ்ட் மீடியத்தினை (எண்ஸ்ரே டை) 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. இப்படங்கள் 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 (புளான் வழுவம் கொண்டதொரு சிறிய சாசேஜ் கொண்டு தமனியை அகலப்படுத்துதல்) என்னும் ஒரு செயல்முறையாகவும் இருக்கலாம். சில நேரங்களில் மருந்துகள் மட்டுமே போதுமானதாக இருக்கலாம்.

கிச்செயல்முறையிலுள்ள இடர்பாடுகள்

இதயச்சுவர் சிறை ஆன்ஜியோகிராஃபியிலுள்ள இடர்பாடுகள் பின்வருபவைகளையே சார்ந்திருக்கும்

- (i) இதயச்சுவர் சிறை தமனி நோயின் தன்மை (ii) இதயத்தின் ஏற்றியிறைத்தல் நிலை (iii) இதயத்தின் வயது மற்றும் பொது ஆரோக்கியம் ஏற்பட வாய்ப்புள்ள சில தீவிர இடர்பாடுகள் பின்வருமாறு. ஆனால் கிடைக்கக் கூடிய மட்டுமே முழுமையான இடர்பாடுகள் 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) மாறடைப்பு (d) எக்ஸ்-ரே கான்ட்ராஸ்ட் மீடியத்தின் (டை) 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 இடர்பாடு. (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 அளவிலான சிராய்ப்பு அல்லது வீக்கம்
பெரும்பாலான மக்களுக்கு	(n) சிறிய அளவிலான சிராய்ப்பு

நோயாளி ஒப்புதல்

மருத்துவர் அவர்கள் என்னுடைய மருத்துவ நிலையையும் மற்றும் முன்மொழியப்பட்டுள்ள செயல்முறையையும் எனக்கு விளக்கினார். செயல்முறையிலுள்ள இடர்பாடுகள், மயக்க மருந்துகள் உட்பட எனக்கு குறிப்பாக ஏற்படும் இடர்பாடுகள் மற்றும் சிக்கல்கள் ஏற்பட்டால் என்னவாகும் என்பவைகளை நான் புரிந்து கொண்டள்ளேன். மருத்துவர் பிற தொடர்புள்ள சிகிச்சை விருப்பத் தேர்வுகள், அதன் இடர்பாடுகள் மற்றும் சிகிச்சை மறுப்பதற்கான என்னுடைய உரிமை ஆகியவைகளையும் எனக்கு விளக்கினார். அவர் என்னுடைய முன் கணிப்புகள் மற்றும் செயல்முறையை மேற்கொள்ளாமல் இருப்பதால் ஏற்பட வாய்ப்புள்ள இடர்பாடுகள் ஆகியவைகளையும் எனக்கு விளக்கினார். என்னுடைய நிலை குறித்து என்னால் கேள்வி எழுப்ப முடிந்தது மற்றும் என்னுடைய கவலைகளை தெரிவிக்கவும், செயல்முறை மற்றும் அதன் பலன்களை தெரிவிக்கவும் மற்றும் எனது சிகிச்சை விருப்பத்தேர்வுகள் குறித்த கவலைகளையும் என்னால் தெரிவிக்க முடிந்தது. என்னுடைய கேள்விகளுக்கும் மற்றும் கவலைகளுக்கும் கலந்தாலோசிக்கப்பட்டது மற்றும் எனக்கு திருப்திகரமான முறையில் அவற்றிற்கு பதிலளிக்கப்பட்டது. அசாதாரணமான சூழலில், எனக்கு இரத்தமேற்றதில், ஒரு கூடுதல் செயல்முறை அல்லது அறுவைசிகிச்சை தேவைப்படலாம் என்பதை நான் புரிந்து கொண்டள்ளேன். உயிருக்கு ஆபத்தினை விளைக்கும் நிகழ்வுகள் ஏற்பட்டால் அதற்கு உடனடியாக சிகிச்சையளிக்கப்படும் என்பதை எனக்கு விளக்கினார். கிச்செயல்முறையினால் என்னுடைய நிலை மேம்படும் என்பதற்கு எந்தக்கூறு உத்தரவாதமும் இல்லை என்பதை நான் புரிந்துகொண்டள்ளேன்.

செயல்முறையை எனக்கு மேற்கொள்ளுமாறு கேட்டுக்கொள்கிறேன்

கையெழுத்து	பெயர்	தேதி	நேரம்
நோயாளி (பாதுகாவலு) உறவுமுறை	MR. EMANUELE	28/12/23	11-35
சாட்சி			
மருத்துவர்			
மொழிபெயர்ப்பாளர்			



JCI ACCREDITED NABH ACCREDITED



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

TRANSRADIAL CORONARY ANGIOGRAM REPORT

Patient Name:	Mr.EMANUVEL R	ID:	MHI202381541
Age/Gender :	52 M	IPH:	IPH2023002620
Cath No. :	3494	DOP:	28.12.2023
Done by	Assisted by	Technician	Physician assistant
Dr.Gnanavelu	Ms. Sathya	Mr. Pratap	Ms. Shalini

DIAGNOSIS: ATYPICAL CHEST PAIN; TMT POSITIVE 8-2023; T2DM; DLP; NORMAL LV FUNCTION

Access: Right radial artery

Total exposure time: 142"

Hardware used: 5F sheath, 5F TIG

Total DAP: 10.65 Gy.cm²

Contrast used: CONTRAPAQUE 50 ml

Total RAK: 41.48 mGy

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

Hemodynamic data: Aortic pressure: 105/73(84) mmHg; HR 94 bpm; SpO2 99%

Selective Coronary angiogram done in multiple angulated views:

ARTERY	FINDINGS
LEFT MAIN	Normal. Bifurcates into LAD & LCx.
LAD	Type 3 vessel. Proximal LAD has luminal irregularities. Mid LAD has myocardial bridging. Distal LAD has luminal irregularities. Gives three minor diagonals and many septals. Diagonals have mild ostial disease
LCx	Non Dominant. Proximal LCx appears normal. Distal LCx has luminal irregularities. Gives 3 OM's, OM1 is a early OM. OM1,2 are major OM's which appear normal.
RCA	Dominant. RCA appears normal. Gives PDA and PLV which appears normal.

FINDINGS: RIGHT DOMINANT SYSTEM ; MINIMAL CORONARY ARTERY DISEASE

ADVICE : MEDICAL MANAGEMENT


Dr. G. GNANAVELU, MD, DM

Dr. 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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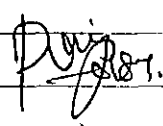


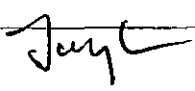
Heart Institute
044 - 4310 8959

Institute of Pulmonology
044-2473 4454

Email : info@medwayhospitals.com | Website : www.medwayhospitals.com | CIN : U74900TN2011PTC083665

MHI/HOSP/2022/118

DATE & TIME	Observation / Action	Signature with Emp.No
28/12/23 @ 11.30	Pt. got admission in RL. Pt V/S are checked and recorded. C.B.G. taken.	
11.40	Pt. Pals Preparation was done.	
11.50	consent taken.	A
11.50 11.50	Pt. shifted to cath lab.	0211.
28/12/23 13.35	<u>CATH LAB</u> ⇒ patient received from RL to cath lab. Pt conscious and oriented.	Pi 0213
13.40	⇒ vitals stable. Dr line left side patient	Pi 0211
13.40	⇒ Sterile drapping done. procedure CAG started	Pi 0213
13.50	⇒ Pt Radial artery approach. under local anesthesia	Pi 0211
13.50	⇒ INJ. NTG 200 mcg + INJ. Heparin 25000 IU given o/b Dr. GA (Sir)	Pi 0213
13.55	⇒ HR: 88 bpm Bp: 130/70 mmHg, SpO2 100% vitals stable.	Pi 0213
14.00	⇒ procedure CAG done. Pt Radial artery Sheath removed. Tight Plaster bandage applied. no oozing no hematoma	Pi 0213
Document endorsed by	Signature 	Name Sathya
	Emp. No. 0016	Date 28/12/23
	Time 14.00	

DATE & TIME	Observation / Action	Signature with Emp.No			
14:20	⇒ patient shifted to RL. all reports handover to RL staff				
<u>28/12/23</u>	<u>Reviewing notes</u>				
15:20	patient received from certified patient concious oriented, we recorded the notes Today CAG done, plan Omt, (R) radial approach. procedure side NO bleeding & Hematoma, pt had g juice, continue the same				
14:40	⇒ pt had diet. pt was stable under the monitoring				
18:00	<u>Discharge notes</u> ⇒ pt iv line removed. ⇒ pt old file, new file handed to pt. pt Attended. ⇒ pt Discharge summary explained to the pt Attended.	 			
18:30	⇒ pt got discharged				
Document endorsed by	Signature	Name	Emp. No.	Date	Time
		JAYABORIS S	002	28/12/23	18-30

SAFE PROCEDURE CHECKLIST
Adapted from WHO Safe Surgery Checklist

Mr. EMANUVEL R
52/Male/MHI202381541
28/12/2023/IPH2023002620
Dr. G. GNANAVELU

III/OT/2022/086
Medway Heart Institute
Every heart beat counts

Name of the Procedure : CAG Location : cath lab II Date & Time : 28/12/23

PATIENT LABEL

Does the Procedure involve Procedural Sedation : ☐ Yes ☒ No

SIGN IN 13.40 Before Induction of Procedural Sedation		TIME OUT 13.50 After procedural Sedation and before procedure		SIGN OUT 14.00 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 <u>CAG</u>	
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 <input checked="" type="checkbox"/> Yes	
Procedure	<input checked="" type="checkbox"/> Yes	Procedures <u>CAG</u>	<input checked="" type="checkbox"/> Yes	Name and site of all specimens / investigations confirms labeling and sent to lab <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA	
Side	<input checked="" type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA	Side <u>RT Radial artery approach</u>	<input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> NA		
		Expected Blood loss <u>NA</u>			
Consent	<input checked="" type="checkbox"/> Yes	Position <u>supine</u>	<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		
		Antibiotic prophylaxis within last 60 minutes	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> NA		
Possibility of hypothermia	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, warmer in place	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 type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> Others pls. specify <u>ECH</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 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 glycemic 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 Date : <u>28/12/23</u> Time : <u>14.10</u>	Doctor performing the Procedure : <u>h</u> Date : <u>28/12/23</u> Time : <u>14.10</u>	Nurse : <u>R. N. parthasarathy</u> Date : <u>28/12/23</u> Time : <u>14.10</u>	Technician : <u>MT. Sathish</u> Date : <u>28/12/23</u> Time : <u>14.10</u>	Others Please Specify : <u>P</u>
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Post Procedure Follow Up Data (to be filled by the doctor)

Time : 14.10

Route : Rt Radial artery approach

Complication : Nil

BP : 128/71 (89) mmHg, HR : 92b/min, RR : 20b/min, SpO2 : 100%

Brachial Distal Pulse: Felt, Puncture Site: No oozing no hematoma

Advise:

- ◆ Shift To: Ward / ICU ICU
- ◆ Bed rest up to 4 hours
- ◆ Observe puncture site for bleeding
- ◆ Watch for Pulse in Rt Radial artery.
- ◆ Diet DM 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 Rt Radial artery dressing on 29/12/23 at 13.50 AM /PM after informing to the consultant.
- ◆ Special instruction if any nil

[Signature]
Name & Signature of Consultant

POST PROCEDURE OBSERVATION

Date & Time	BP	HR	RR	SpO2%	Site Evaluation	Extremity Status	Remarks	Sign. of Nurse

Nurses Notes :

procedure CAA done. Rt Radial artery sheath removed. right plaster bandage applied, no oozing no hematoma

Condition at the end of procedure : ☒ Stable ☐ Critical

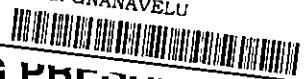
Patient shift to : ☐ Recovery Room ☐ Patient Room ☐ CCU ☒ Other PL

Name & Signature of the Nurse :

Date & Time : 28/12/23

[Signature]

14.30



BRADEN SCALE FOR PREDICTING PRESSURE

U RISK

SENSORY PERCEPTION ability to respond meaningfully 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	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	4	-
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	4	4	-
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and / or maintained on clear liquids or IV's for more than 5 days	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or 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	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 independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair		3	3	-
					TOTAL SCORE		
					23		
					Initial & Emp. No. of Staff Nurse:		
					2024/12/28		
					Initial & Emp. No. of Sr. Staff Nurse:		
					2024/12/28		

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.
28/12/23 09:30	0/10	No Pain	—	—	—	Dr. Jay	Dr. Jay
		Patient cleaned room with Lab. at 14:30					
14:20	0/10	No pain	Nil	Nil	Nil	Dr. Jay	Dr. Jay
15:30	0/10	No pain	—	—	—	Dr. Jay	Dr. Jay
16:30	0/10	No pain	—	—	—	Dr. Jay	Dr. Jay
17:30	0/10	No pain	—	—	—	Dr. Jay	Dr. Jay
18:30	0/10	No pain	—	—	—	Dr. Jay	Dr. Jay
				Plc			

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 ≤ 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)	<p>0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worst</p> <p>Numerical Rating Scale (age more than 12 years)</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>None Mild Moderate Severe</p>
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	



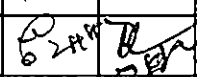

DVT RISK ASSESSMENT

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	28/12/23						
		Time	11:30						
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 ESKD / 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		0							
DVT prophylaxis started		<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature & Emp. No. of RN		02/11							
Signature & Emp. No. of Sr. RN		00/11							



MODIFIED MORSE FALL RISK ASSESSMENT CHART

Variables	Date									
	Time									
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	00	0	0	0	0	0	0	0
	Yes	(15)	(15)	15	15	15	15	15	15	15
Total Score		35	35							
Low Risk (0 - 24)		—	—							
Medium Risk (25 - 44)		✓	✓							
High Risk (45 or above)		✗	—							
Signature & Emp. No. of RN		 5244								
Signature & Emp. No. of Sr. RN		 5244								

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

[illegible]