

[illegible]

[REDACTED]
28 June 1995

Dr [REDACTED]
[REDACTED]

Dear Dr [REDACTED]

RE: [REDACTED] DOB 22.04.34

UR [REDACTED]

I have recently received this lady's thyroid function test results following her admission to the [REDACTED] Hospital with an episode of atypical chest pain in mid-June this year. This shows that she is hypothyroid with Free T4 level of 8pmol/L (9-23) and a TSH of 35mIU/L (0.05-5.0). In addition her thyroid antibodies show she has an elevated thyroid microsomal level at 4490 and elevated thyroglobulin at 1733. In addition her speckled nuclear antigens are elevated at Titre 160.

I understand this lady has been previously told she is hypothyroid and commenced on Thyroxine some time ago however she elected to cease this herself. It would appear from these results that she certainly does need Thyroxine and I would be grateful if you could see her in order to go over this with her. As she has an outpatient appointment with Dr [REDACTED] for an exercise tolerance test on 3 July this year I have sent a copy of this letter to him.

Yours sincerely

[REDACTED]
Medical PHO for Dr [REDACTED]

Copy to Dr [REDACTED]

Signed by Dr [REDACTED]

GP/lm

10th September 1993

Dr [REDACTED]
[REDACTED]

Dear [REDACTED]

RE: [REDACTED] DOB 22/4/34

UR [REDACTED]

This patient was admitted in my absence on leave in June having sustained a myocardial infarct.

There were no initial ECG changes and so Streptokinase was not given, CK subsequently peaked at around 700. She had a previous history of myocardial infarction in 1988 and had also been advised to take treatment for hypothyroidism but had discontinued. Clinically she was apparently not hypothyroid.

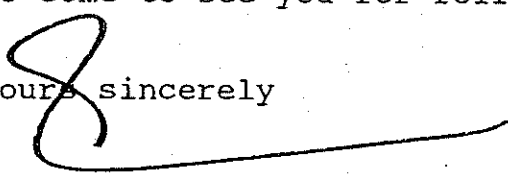
She was subsequently discharged on the 28th. June on treatment with Anginine PRN, Aspirin 150mgs, Atenolol 50mgs, Imdur 60mgs and Thyroxine 100 micrograms daily. When reviewed today she seemed still to have limited exercise capability and was having minor pains with exertion although not taking treatment.

Follow up thyroid function tests taken 2 weeks ago were within normal range. A fasting cholesterol was a little increased at 6.3 but with a low HDL at 0.99 indicating increased risk.

Today she was also complaining of some discomfort and numbness in the left thigh area which sounded like nerve compression symptomatology.

On examination she looked well, still moderately overweight at 75 kilos. Cardiovascular and respiratory examination normal with blood pressure 130/90. ECG showed that the previously noted changes in the inferior leads had recovered.

This patient should continue to recover as she loses weight and her thyroid recovers. Should she continue to have niggling pains onward referral to Brisbane for angiography may be necessary, for the moment as her ECG does seem to have improved I have not made any specific plans. I have asked her to come to see you for follow up.

Yours sincerely


[REDACTED] - VISITING PHYSICIAN

0246

CLINICAL SUMMARY

22-04-1934

M

Usual GP.....

Ph (H).....

Address.....

Ph (B).....

Catholic, nec



HOME DUTIES

Admission Date:

1/12/03

Discharge Date:

2/12/03

Follow-up Clinic:

PHO

Referral:

Principal Diagnosis: (one only) The condition which after study, was found to be the main reason for the patients admission.

Chest pain

Secondary Conditions:

old MI

Hypothyroidism

Principal Procedure:

Type of anaesthetic:

☐ Local

☐ Sedation

☐ General

☐ Spinal

☐ Epidural

Secondary Procedure/s and or Significant Non-Surgical Procedures:

Complications:

☐ Wound infection (include organism)

☐ Urinary tract infection (include organism)

☐ Chest infection

☐ Adverse drug reaction

☐ Haemorrhage/haematoma

☐ DVT

☐ Pulmonary embolism

☐ Others (please specify below)

External Cause of Injury/Poisoning:

Clinical Course and Significant Results:

Unstable angina / Non ST ↑
MI

See typed
letter

Enclosed by Mail

Abnormal results

☐ ECG

☐ Radiology reports

☐ Haematology

☐ Histopathology

☐ MBA20

☐ Other

DISCHARGE MEDICATION/DOSAGE:

Thyroxine 100mcg/d
Aspirin 100mg/d
Lipitor 20mg/d
Lasix 40mg/d

DISCHARGE MEDICATION/DOSAGE:

MO Signature: _____

Print name: _____

Designation: _____

Date: _____

Consultant: _____

2/12/03

0245

MR53

CLINICAL SUMMARY

[REDACTED]
22/4/1934

2/12/03 (ward round)

Dear Doctor

69 year old lady with prior history of silent MI presented with chest pain relieved by Nitroglycerin. Her Troponin was 0.6 with a flat CK curve. ECG shows old MI.

Past medical history

Prior MI (silent)
hypothyroidism

Meds

Aspirin 100mg OD
Lasix 40mg OD
Lipitor 20mg OD
Thyroxine 100mcg OD

Assessment

Unstable Angina/ Non ST Elevation MI

Plan

1. Booked for a stress sestamibi 8/12/03
2. Started on aspirin and lipid lowering agent.
3. Will hold off beta blockers until stress test performed to allow for an adequate study
4. Started on lasix. Will need to assess long term need based on EF and follow up exam.

Thank you

[REDACTED]
Med PHO
[REDACTED]

Date: 02.12.03
Time: 12:05:44

Discharge Medication List-GP & Pharmacy

Page: 1

Script Patient Name

Script label

ASIRIN 100mg

ATORVASTATIN 20mg (Lipitor)

FRUSEMIDE 40mg (Lasix eq)

THYROXINE 100mcg (Oroxine)

Take ONE tablet each MORNING

Take ONE tablet DAILY

Take ONE tablet each MORNING

Take ONE tablet each MORNING

KEEP OUT OF THE REACH OF CHILDREN

HOSPITAL PH: 07-

This list of medication is the latest information the pharmacy can determine. There may be drugs which have been omitted as a pharmacist has not taken a full history.

HOSPITAL

No.

Date

2/12/03

0242

22-04-1934

M

GENERAL OBSERVATION SHEET

Ph (H)

Ph (B)

Catholic, nec

HOME DUTIES

DATE	1/12/33		2	3	4	5	6							
TIME	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
TEMPERATURE °C	41.5													
	41													
	40.5													
	40													
	39.5													
	39													
	38.5													
	38													
	37.5													
	37													
	36.5													
	36													
35.5														
PULSE BLOOD PRESSURE	260													
	250													
	240													
	230													
	220													
	210													
	200													
	190													
	180													
	170													
	160													
	150													
RESPIRATIONS	120													
	115													
	110													
	105													
	100													
	95													
	90													
	85													
	80													
	75													
	70													
	65													
BOWELS	WWT - NAD													
WEIGHT														
FOETAL HEART														
URINE PROTEIN	ALBUSTIK													
	BOIL													

Hospital

SEX
F

UR NO

22-04-19

SPECIFIC ORIGINATOR SHEET

Ph (H)

Ph (B)

Catholic, nec



HOME DUTY

EXAMPLE:

- FINGERS/TOES - Colour, temp, movement, swelling, pain, numbness, Remarks
- URINE - Vol, colour, reaction. SG. Albumen, Blood, sugar, bile, Remarks

OBSERVATIONS RECORDED: URINE ☐ FINGERS/TOES ☐ OTHER.....

INDICATE OBSERVATIONS IN SEPARATE COLUMNS

DATE	TIME	T	P	R	Slr	O ₂	Sat.	Pain	REMARKS
1/12/03	0446		90	18	145/85	RA	94%	0/10	0330 Chest Pain Central radiating 5/10 in back.
	0452		ECC ①				O ₂ reappplied via Hudson		1/1 Anginine ↓ 0/10
	0455		IV		Camelo inserted & blood collected		@ 6cm		1/1 Aspirin BSL 7.3mmol/l
	0500		82		125/94	6L	99%	0/10	
	0515	37.2	136	20	116/78	6L	99%	0/10	Periods of Tachycardia & Arrhythmia
	0530		76-131	30	121/75	6L	99%	0/10	
	0545		95		129/95	6L	100%	0/10	68.2 Kgs Wt.
	0605		86-135	20	135/90	6L	99%	0/10	

22-04-1934

M

RADIOMETER PRINTOUTS

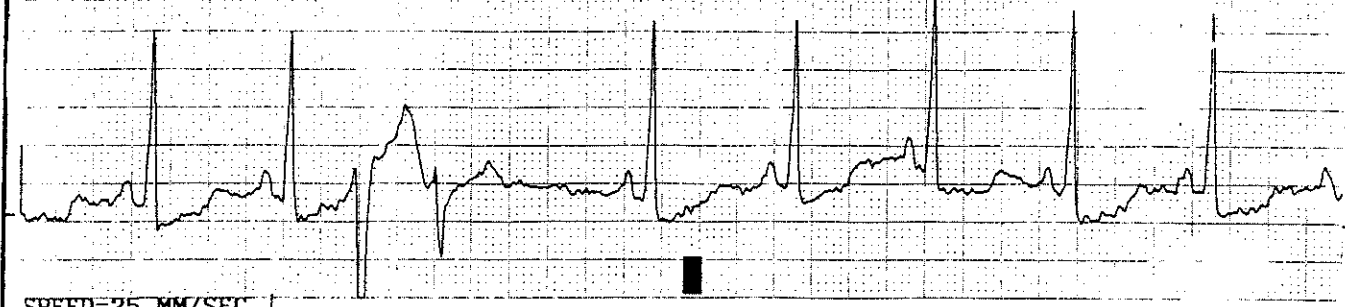
Ph (H)

Ph (B)

Catholic, nec

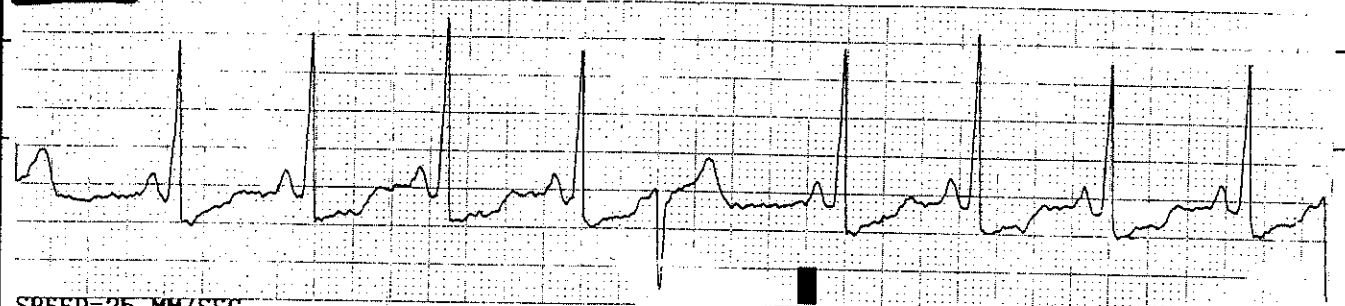
HOME DUTIES

BED02 08:30 01DEC2003 II MON HR =138 A=10 *ALARM* HI LIMIT=130



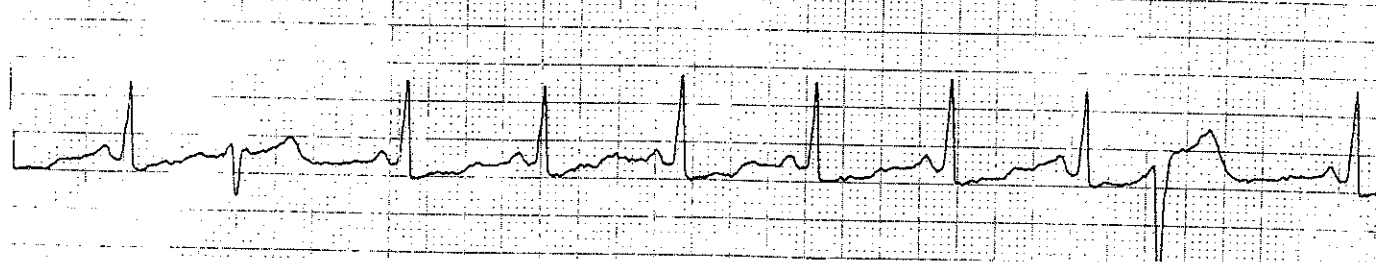
SPEED=25 MM/SEC

BED02 12:22 01DEC2003 II MON HR =89 A=14



SPEED=25 MM/SEC

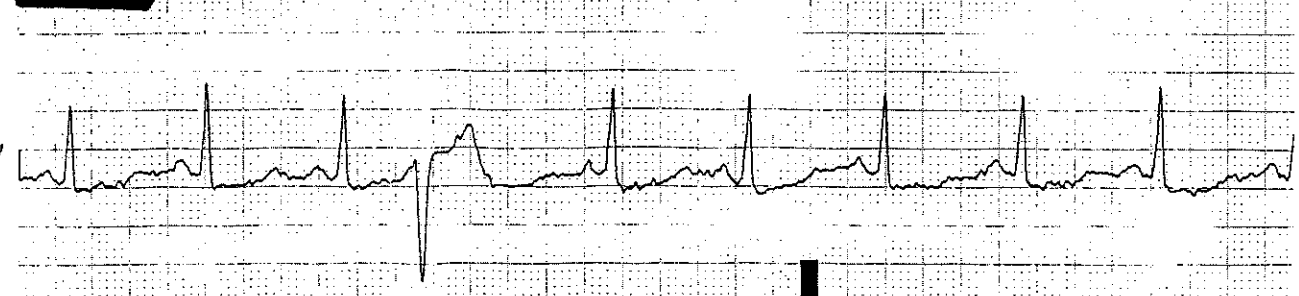
BED02 13:28 01DEC2003 II MON HR =84 A=4



SI BED02 14:58 01DEC2003 II MON HR =144 A=40 *ALARM* HI LIMIT=130



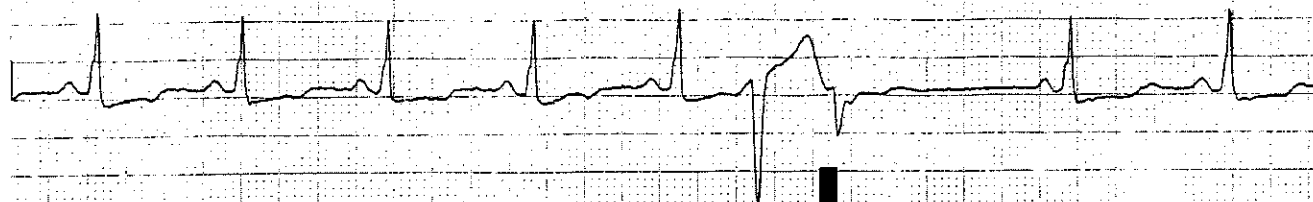
BED02 18:40 01DEC2003 II MON HR =83 A=11



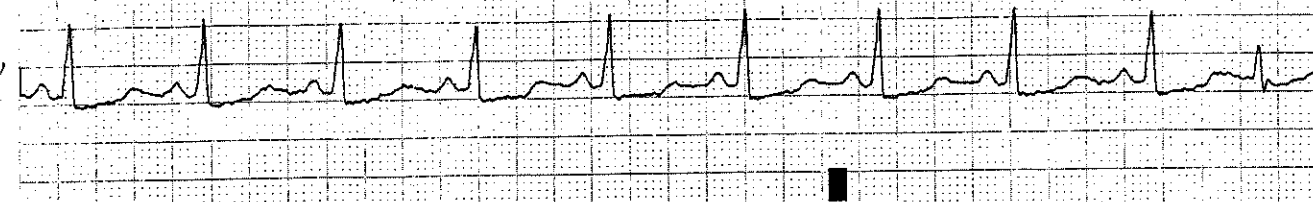
SPEED=25 MM/SEC

MR62G

0239



BED02 21:04 01DEC2003 II MON HR =83 A=0



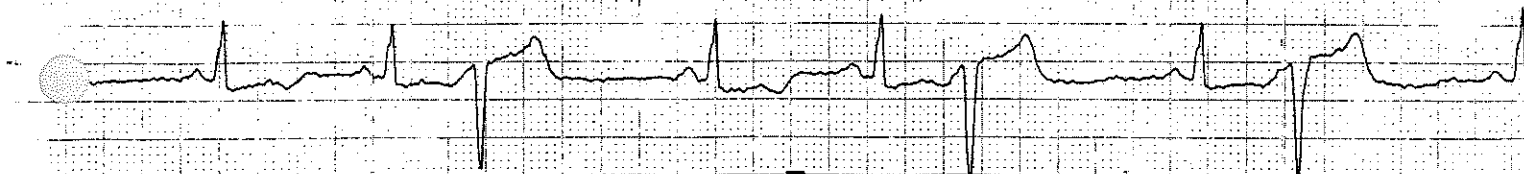
BED02 22:31 01DEC2003 II MON HR =73 A=10



BED02 23:33 01DEC2003 II MON HR =67 A=10



BED02 01:25 02DEC2003 II MON HR =70 A=25



BED02 02:28 02DEC2003 II MON HR =67 A=22



SPEED=25 MM/SEC

RADIOMETER
PRINTOUTS

Surname: [REDACTED]

First Names: [REDACTED]

U.R. No: [REDACTED]

Date of Birth: 22/04/34

(Please affix Patient ID label here if available)

BED02 03:29 02DEC2003 V1 MON HR =74 A=36



BED02 04:30 02DEC2003 II MON HR =87 A=21

END OF PAGE

SPEED=25 MM



SPEED=25 MM/SEC



HEALTH SERVICE DISTRICT

PATIENT PROFILE

Ph (H)

Ph (B)

Catholic, nec

HOME DUTIES

Date: 1.12.03 Time Admitted to Ward: 6.45 hrs

Information given by: Patient ☐ Relative ☐ Other: ☐

Presenting Problem/illness/Reason for Admission:

Chest pain

Preferred name:

Correct name band in place: Yes ☒ No ☐

Relatives aware of admission: Yes ☒ No ☐

(include accident/injury details)

Allergies or Reactions:

Nil

Is patient on any medication: Yes ☒ No ☐

Medication brought in: Yes ☒ No ☐ N/A ☐

Polypharmacy > 5 drugs: Yes ☐ No ☐ N/A ☐

Communication:

Coherent: Yes ☒ No ☐

Incoherent: Yes ☐ No ☐

English spoken: Yes ☒ No ☐

English understood: Yes ☒ No ☐

Interpreter needed: Yes ☐ No ☐

Other language preferred:

Impairment:

Speech: Yes ☐ No ☒ Speech pathology notified Yes ☐ No ☐

Hearing: Yes ☐ No ☒ Hearing aid Yes ☐ No ☐

Retained by patient Yes ☐ No ☐

Sight: Yes ☐ No ☐ Glasses/contact lenses Yes ☐ No ☐

Retained by patient Yes ☐ No ☐

Social History:

Does patient smoke: Yes ☐ No ☒

Did patient smoke: Yes ☒ No ☐

Does patient drink alcohol: Yes ☐ No ☒

Does patient have problems sleeping: Yes ☐ No ☒ Sleep pattern

Does patient live alone: Yes ☒ No ☐

Family support: Yes ☒ No ☐

Whom and what support: husband

Prior to admission was patient receiving:

Meals on Wheels Yes ☐ No ☒ Notified: Yes ☐ No ☐

Home Help Yes ☐ No ☒ (if applicable) Yes ☐ No ☐

Domiciliary Nursing Yes ☐ No ☒ Yes ☐ No ☐

St Vincent Yes ☐ No ☒ Yes ☐ No ☐

Blue Care Yes ☐ No ☒ Yes ☐ No ☐

Community Health Yes ☐ No ☒ Yes ☐ No ☐

Oxygen therapy Yes ☐ No ☒ Yes ☐ No ☐

Does the patient have any concerns regarding hospitalization:

Spouse Yes ☐ No ☐

Children Yes ☐ No ☐

Transport Yes ☐ No ☐

Accommodation:

Lives in own home Yes ☐ No ☐

Lives in nursing home Yes ☐ No ☐

Lives in hostel Yes ☐ No ☐

Other:

Someone to care for them Yes ☐ No ☐

Special needs:

Personal care status:

Independent Assist Dependant

Hygiene/shower/bath ☒ ☐ ☐

Mobility/transfer ☒ ☐ ☐

Meals/feeding ☒ ☐ ☐

Dressing ☒ ☐ ☐

Toileting ☒ ☐ ☐

Medical History

Chest infection Yes ☐ No ☒

Asthma Yes ☐ No ☒

Pneumonia Yes ☐ No ☒

Cardiac problems Yes ☒ No ☐

Diabetes Yes ☐ No ☒ Which type (1 or 2)

Epilepsy or fits Yes ☐ No ☒

Previous operations/illness:

M1 x 3

General appearance:

Skin: General condition:

Pressure areas: Yes ☐ No ☐

Heels:

Sacrum:

Other:

Wounds

Site(s): _____
Current dressing: _____
Frequency: _____
Slow wound healing Yes ☐ No ☐ Bleeding tendency Yes ☐ No ☐

Nutrition

How does patient describe their appetite: Poor ☐ Fair ☐ Good ☒ Dietitian needed Yes ☐ No ☐
Special diet Yes ☐ No ☐ Details: _____
Diet and food preference: _____

Spiritual needs

Religious needs: _____
Pastoral care required Yes ☐ No ☐ Contact: _____
Cultural needs: _____
Emotional state: _____

Dentition

Full denture Yes ☒ No ☐ Partial denture Yes ☐ No ☐ Prosthesis: _____
Upper denture Yes ☒ No ☐ Lower denture Yes ☒ No ☐ With patient Yes ☐ No ☐

Mobility aids (Wheelchair, walking stick, etc)

Specify: _____
With patient: Yes ☐ No ☐ Allied health notified: Yes ☐ No ☐ N/A ☐

PAC nurse signature

Printed name/designation

Date

*To be completed on admission:***Condition of patient on arrival:**

Level of Consciousness:

Fully conscious: Yes ☒ No ☐ Drowsy: Yes ☐ No ☒Unresponsive: Yes ☐ No ☒If unresponsive, response to stimuli: Verbal: Yes ☐ No ☐Pain: Yes ☐ No ☐Have base line observations been done? Yes ☒ No ☐

Emotional state: _____

Thought Process:

No problems noted: Yes ☐ No ☒Confused/vague: Yes ☐ No ☒

Comments: _____

Is the patient cyanosed: Yes ☐ No ☐**MRSA**Transfer from another facility Yes ☐ No ☐ Transfer notes in file Yes ☐ No ☐ N/A ☐Swabs required Yes ☐ No ☐ Swabs taken Yes ☐ No ☐ Date _____**Risk Assessment** (write score next to assessment)Pressure areas Waterlow's scale documented Yes ☐ No ☐ Score _____ Notes: _____Falls Risk Yes ☐ No ☐ Score _____Heart start risk Yes ☐ No ☐ Score _____Diabetes risk Yes ☐ No ☐ Score _____**Valuables**With patient Yes ☐ No ☒ Articles kept with patient: _____Taken home Yes ☐ No ☐ X-rays with patient Yes ☐ No ☐Trust facilities offered Yes ☐ No ☐ N/A ☐ Placed in trust Yes ☐ No ☐ N/A ☐**Unit orientation**Call bell ☒ Visiting hours ☒ Smoking rules ☒ NOK/contact details checked ☒Lights ☒ Menu/meals ☒ Television ☒ Family notified (DEM admission) ☒Bathroom/toilet ☒ Telephones ☒ Qld Health Public Patient Charter explained/given ☐Fire exits and evacuation procedures ☐ Specific instructions: _____**Notes:**

Admitting nurse signature

Printed name/designation

RN

1/12/03
Date

0235

MR69

[illegible]

HOME DUTIES

0234

[REDACTED] Hospital [REDACTED]
[REDACTED]
[REDACTED]

Hospital

SEX
F

UR NO
[REDACTED]

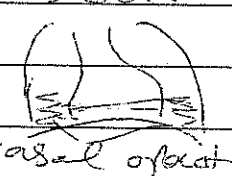
22-04-1934
M

Ph (H)
Ph (B)
Catholic, nec



CONTINUATION SHEET

HOME DUTIES

DATE AND TIME	HISTORY, EXAMINATION AND TREATMENT
01/12/03	FBC => Normal
0555	LFT => Normal ; CXR Basal urec => Normal = opacity off CK Troponin => 0.52 ↑ DIW STRAHAN: → For Admission and put on Lasix.  (P) → Admit → Lasix 60mg IV stat → Prop-up → O2 at 6L/min → For M.I screen in ward. → NO Telemetry available in ward 10. To wait for medical team to Rev. at 0800h. → Thyroxin 100mcg po daily → ARTN 30mg po prn. <u>1.5</u>
1/12/03 0725hrs	Nursing: Pt settled into bed. Placed on telemetry. Informed of RIB policy. Wtu-mad. Pu✓ [REDACTED] RN [REDACTED]
1045	Heard that Visit states President Ht "Regard, attacks" not interested in further information at this time. [REDACTED] RN [REDACTED]

MR5
0233

DATE AND TIME	HISTORY, EXAMINATION AND TREATMENT
1/12	WRe Dr [REDACTED]
	Known CAD, prior MI
	S/Sx heard 50-60 chest sounds clear
	ECC old inf - antecub MI late 8/2
	Plan
	urgent CK
	if normal → stress test today 1130am
	[REDACTED]
	[REDACTED]
1/12	CK 120 122
	Plan
	Stress Sestamibi Tc 99m
	12:15 next Monday & Wed. 8/12 + 10/12.
	[REDACTED]
	[REDACTED]
	if MI CK came Flat → Dr to home
	[REDACTED]
1/12/03	Resting in bed. Nil complaints of chest
14:40	pain. CE2 and trop. attended @ 12:00.
	Meds given as per MR85 - [REDACTED] Student [REDACTED]
	[REDACTED] RN [REDACTED]
1/12/03	Nursing: Pt has been RIB this shift. No
2200	complaints of chest pain. Meds as per MR85
	Cares as per care path - [REDACTED] RN [REDACTED]

.....HOSPITAL

HOSPITAL

SEX

UR NO

F

22-04-1934

M

Ph (H)

Ph (B)

Catholic, nec

HOME DUTIES

INPATIENT PROGRESS NOTES

DATE AND
STAFF CATEGORY

PROGRESS NOTES
ALL NOTES MUST BE CONCISE AND RELEVANT

2/12/03 0500hr Rested quietly on. Telemetry
cont. on.

2/12/03 mobile & spacing. Nil to record.

1430hrs Discharged home - RN(

Ph (H) [REDACTED]
Ph (B) [REDACTED]
Catholic, nec



HOME DUTIES

INDICATOR	D.E.M.	1	2	03	Day 0 (First 24 Hrs)	1	2	03	Day 1
DOCTORS	☒ Medical assessment ☐ Physician notified ☐				☐ Medical review ☐				☐ Medical review ☐ Heartstart referral ☐
TESTS	☒ FBC, Urea & Electrolytes, LFT's, ☒ Creatinine, Glucose, ESR ☐ CRP, Troponin, Coagulation ☐ profile ☒ Ck no.1 @ 0500 hrs ☒ Troponin No 1 @ 0500 hrs ☒ 12 lead ECG ☒ CXR ☒ BSL (if applicable) ☐				☐ CK post presentation ☒ 6hrs @ 1100 hrs (Rpt ☐ Troponin if -ve) ☒ Troponin No 2 @ 1700 ☐ hrs (if -ve) ☐ 12 hrs @hrs ☐ 18 hrs @hrs (if ☐ indicated) ☐ 24 hrs @hrs (if ☐ indicated) ☐ Fasting Lipids & Glucose ☐ ECG on admission to CCU ☐ ECG pre Thrombolytic therapy ☐ ECG 1/2 hr post Thrombolytic ☐ therapy ☐ CXR (if not attended in DEM) ☐ APPT 4 hrs post thrombolytic ☐ therapy ☐ APPT 8 hrs post Thrombolytic ☐ therapy ☐ APPT 4 hrly if Heparin infusion ☐ given				☐ ECG ☐ APPT BD if heparin infusion ☐ given ☐
OBSERVATIONS	☒ TPR, BP & SaO2 ☒ Cardiac monitoring ☐ Urinalysis (if pt voids)				☐ Norton Scale..... ☐ TPR, BP SaO2..... ☐ Cardiac Monitoring ☐ Fluid Balance Chart ☐ Urinalysis (if not attended in ☐ DEM) ☐ Observe IV cannula site Day..... ☐ Eve.....ND..... ☐				☐ Norton scale..... ☐ TPR, BP, SaO2..... ☐ Cardiac monitoring ☐ Fluid balance chart ☐ Observe IV cannula site Day... ☐ Eve.....ND..... ☐ Weight ☐
MEDICATIONS	☐ Commence Thrombolysis agent ☐ if ICU bed unavailable within ☐ 15 - 20 minutes ☐ Tidal Infusion if indicated ☐ Medications as indicated:- ☐ Heparin / Anticoagulant ☒ Aspirin ☐ Pain relief ☐ Antiemetic ☒ O2 4 L/min 6LPM				☐ Medications as indicated:- ☐ Thrombolytic agent ☐ GTN if indicated ☐ Anticoagulant ☐ Morphine ☐ Atenolol ☐ Nitrates ☐ Sedation ☐ Antiemetic ☐				☐ Medications as indicated:- ☐ Anticoagulant - Cease Heparin ☐ infusion at 48 hrs ☐ Aspirin ☐ Morphine ☐ Atenolol ☐ Nitrates if indicated ☐ Sedation ☐ Aperient ☐
TREATMENTS	☒ IV access X1 cannulas ☐				☐ Active limb exercises hrly ☐ Deep breathing exercises hrly ☐				☐ Active limb & breathing ☐ exercises hrly ☐
MOBILITY					☐ Rest in bed ☐ Mandatory rest periods for 30 ☐ minutes post meals & ☐ afternoon rest period				☐ Sit out of bed 15 - 30 minutes ☐ AM..... PM..... ☐ Mandatory rest periods ☐
RN (Day)									
RN (Evening)									
RN (Night)									
Allied Health									

INTAKE

OUTPUT

Time	ORAL N/G			PERIPH. I.V.			PERIPH. I.V.			C.V.L.			URINE		DRAINS		DRAINS			BOWEL		
	TYPE	HRLY. VOL	TOTAL	TYPE	HRLY. VOL	TOTAL	TYPE	HRLY. VOL	TOTAL	TYPE	HRLY. VOL	TOTAL	HRLY. URINE	TOTAL		TOTAL		TOTAL		TOTAL		TOTAL
0100																						
0200																						
0300																						
0400																						
0500																						
0600																						
0700													100	100								
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2100																						
2200																						
2300																						
2400																						
TOTALS																						

0229

INTAKE: ORAL N/G I/V C.V.L. TOTAL MEASURED BALANCE ± WEIGHT
OUTPUT: URINE N/G I.C.C. DRAINS TOTAL TRUE BALANCE

██████████ Hospital
██████████
██████████
██████████
Ph (HD) ██████████

SEX
F

UK 200

22-04-1934

M

Ph (H) [REDACTED]
Ph (B)
Catholic, nec



HOME DUTIES

PRN ADMINISTRATION				Date	Time	Dose	Sig	Date	Time	Dose	Sig	Date	Time	Dose	Sig	Discharge Supply ☐ days Dr's Signature Pharmacist
DRUG GTN																
ROUTE	DOSE	FREQ.	START													
Sublingual Tablet 10mg po qid			7/12													
DOCTOR [Redacted]			Time check													
PRN ADMINISTRATION				Date	Time	Dose	Sig	Date	Time	Dose	Sig	Date	Time	Dose	Sig	Discharge Supply ☐ days Dr's Signature Pharmacist
DRUG																
ROUTE	DOSE	FREQ.	START													
DOCTOR			Time check													
PRN ADMINISTRATION				Date	Time	Dose	Sig	Date	Time	Dose	Sig	Date	Time	Dose	Sig	Discharge Supply ☐ days Dr's Signature Pharmacist
DRUG																
ROUTE	DOSE	FREQ.	START													
DOCTOR			Time check													
PRN ADMINISTRATION				Date	Time	Dose	Sig	Date	Time	Dose	Sig	Date	Time	Dose	Sig	Discharge Supply ☐ days Dr's Signature Pharmacist
DRUG																
ROUTE	DOSE	FREQ.	START													
DOCTOR			Time check													

DRUGS WITH VARIABLE DOSE

[illegible][illegible]

0228

UR NO

Catholic, nec

HOME DUTIES

DISCHARGE SUMMARY

Local Doctor

Address

DR

22-04-1934 M

Ph (H)

Ph (B)

CATHOLIC

Admission Date

12/6/95

Discharge to

Clinic

Appt. date

time

Symptoms/signs on presentation

1 HR central chest pain.

Silent anteroapical + inf. MI in past

PHx Hypothyroidism.

? MI

ADMITTING DIAGNOSIS

* PRINCIPAL DIAGNOSIS

Atypical Chest Pain.

Secondary Diagnoses

PRINCIPLE PROCEDURE

Secondary procedure/s

INVESTIGATIONS:

WRITE ABNORMAL RESULTS

F.B.C.

Y N NAD

BIOCHEM

L.F.T.'s

MICRO

HISTOLOGY

X-RAY

CT SCAN

E.C.G.

OTHER

Serial CEs (N)

ECG - no new changes

FBC (N) MBA (N)

Awaiting TFT / Lipids - copy to LMO

Clinical Course/Complications

Booked for ETT as outpt. - appt 3/7/95.
1.30pm

Cause of injury/poisoning (if applic.):

Place of Occurance:

Medication on Discharge

Aspion 150mg daily

Anginine + s/L pm

R.M.O.

(sign)

(print)

DATE

14.6.95

CONSULTANT

(sign)

(print)

DATE

0226

* Definition : The condition which after study, was found to be chiefly responsible for occasioning the patient's admission to hospital.

DISCHARGE SUMMARY

HOSPITAL

-- ID -- -- SEX -- -- UR NO --

F

22-04--

GENERAL OBSERVATION SHEET

Ph (H)

Ph (B)

CATHOLIC

DATE		12.6.95		13.6.95		14.6.95		15.6.95							
TIME	1200	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
TEMPERATURE °C	41.5														
	41														
	40.5														
	40														
	39.5														
	39														
	38.5														
	38														
	37.5														
	37														
	36.5														
	36														
	35.5														
PULSE BLOOD PRESSURE	260														
	250														
	240														
	230														
	220														
	210														
	200														
	190														
	180														
	170														
	160														
	150														
	140														
RESPIRATIONS	120														
	115														
	110														
	105														
	100														
	95														
	90														
	85														
	80														
	75														
	70														
	65														
	60														
55															
50															
45															
40															
35															
30															
25															
20															
15															
BOWELS		i		h											
WEIGHT		71.2 kg													
FOETAL HEART		147 J													
URINE PROTEIN	ALBUSTIK	NAD.													
	BOIL														

TIME: 1300

WARD: [REDACTED]

KNOWN ALLERGIES Nil Known
(Record in red)

Ph(H)
Ph(B)
CATHOLIC

22-04-1934

M

PATIENT MEDICATIONS: YES/NO (NO)

NURSING OBSERVATIONS

Colour Pink Skin State Intact.

Discomfort/Pain Chest pain now resolved

Duration of Discomfort/Pain 1/2 hour

Communication Problems Nil

Visual Problems Reading glasses.

Other Problems -

ORIENTATION

Hospital and Ward routine explained ✓

Nursing Personnel ✓ Doctors visit ✓ Use of Buzzer ✓

VALUABLES

In Trust - To relatives - Retained by patient -

Articles entered into 'Clothes Book' Yes/NO (NO)

Do you have glasses? (Yes/No) Retained by patient Yes/No Did not

Entered into 'Clothes Book' Yes/NO (NO)

What do you understand is the reason for your admission to Hospital?

Chest pain.

Is your family aware of your admission? Yes.

Are you concerned about fulfillment of usual responsibilities?
(Family, animals, work, etc.)

No problems.

Sleep and Rest habits. (Sedation, bed type, etc.) No problems.

Special Diet Healthy Heart

Bowel and Bladder Habits (Laxitives, bran, etc.) No problems

Do you have a responsible person at home to assist you following your hospitalisation? husband.

Do you receive any community service? Yes/NO (NO)

If yes, state which service/s.

Ambulance Subscriber Yes/NO (NO)

[REDACTED] (NO)

NURSES SIGNATURE & DESIGNATION

To be used for patients in hospital > 48 hours.

Revised October, 1993.

MR 69 A

STK NO. 7799069

MR69A

0222

.....HOSPITAL

--ID--SEX--UR NO--

F

22-04-19

INPATIENT PROGRESS NOTES

Ph (H)
Ph (B)
CATHOLIC

DATE AND
STAFF CATEGORY

PROGRESS NOTES
ALL NOTES MUST BE CONCISE AND RELEVANT

12/6/95

PHO

6 years of

12. 20

PC

Chest Pain

HPC

H/o MI x 2

Last one 2 years ago

No H/o Angina since

Today sudden onset of central
Chest pain whilst at rest; also between
Breasting Provider blades

Radiating across chest
felt SOB

Nausea on

Vomited x 1

Not clammy

Pain worse than that of MI but of
similar nature

Not pleuritic

No cough No haemoptysis

RF

Major Angina

Nausea

Previous MI x 2

NOT BP

0222

NOT Diabetes
not ↑.

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
PMH	as over Ros Nil to add
DH	Name usually well
smokes	Name
allergies	Name
SH	NK
	Lives w husband
OE	Lwen but anxious
	Not anemic
	Pulse 57
	BP 122/65
	NP →
	HJ I + II
	RR 18/min Nontender to springing
	Chest few creps
	and soft
	Nontender
	No masses
	BS ✓
	CNS anxious but grossly (w)
	<u>Imp</u> ? oesophageal spasm / Reflux.
	To rule out cardiac cause
	For C enzymes sent
	MRSA ✓
	BC -
	CXR -
	Sent ECG. ECG? old MI

(2)

INPATIENT PROGRESS NOTES

Ph (H)
Ph (B)
CATHOLICDATE AND
STAFF CATEGORYPROGRESS NOTES
ALL NOTES MUST BE CONCISE AND RELEVANT

12/6/95

Routine obs

Noisy cardio if the pleural
any further chest pain. [redacted] PMO.

12-6-95

Nursing 1300 hrs. Admission via A+E
as above. Settled into ward. Observations
satisfactory. For CE no 2 this pm.
No complaints of chest pain since
arrival to ward. — [redacted] RN

12/6/95

INTERN.

61 y.o. f.

PC

Chest pain - severe (7/10),
dull, 'tight'
feeling in centre
of chest (retro-
sternal)

- pain radiated through to back at times. No radiation to neck/jaw/arms
- pain lasted ~1/2 hr to 1 hour gradually receded (didn't take anything for it)
- felt nauseous, cold + clammy, vomited x 1
- nausea passed as pain did
- no dizziness/syncope
- no acid reflux into mouth/throat. (Never suffered with heartburn/reflux)

- no obvious trigger for pain (was doing very light housework at onset), pain didn't ease with rest.

Hx of IHD - MIs x 2

1st MI ~ 8 yrs ago

2nd MI ~ 2 yrs ago

- * Reports no chest pain before/between/since MIs until today

RISKS

- * family Hx - mother had angina
Not deceased? cause

- father deceased of
bronchial asthma

- * smoker until ~ 8 yrs ago

Smoked 30-40/day for ~ 35 yrs.

- * cholesterol/TG → not known from chart - ↑ chol '93

- * no HT known, no DM

- * obese

PMHx

- MIs x 2 ~ 8 yrs ago
~ 2 yrs ago
- hypothyroidism - not taking
thyroxine at present

PSHx

- nil.

family Hx - (as above) (M) had angina

social Hx - lives with husband

+ 16 y.o. son (adopted)

- * allergies - N/R

- * alcohol - none

- * tobacco - none
- * medications - none.

INPATIENT PROGRESS NOTES

DATE AND
STAFF CATEGORY

PROGRESS NOTES
ALL NOTES MUST BE CONCISE AND RELEVANT

O/E Afabula, in no distress
CVS HR = 60 BP = 110/20 JVP NE
HS x 2, no murmur

Resp chest expansion fair
breath sounds vesicular
no crackles/wheezes

Abdo soft, obese, non-tender
no masses/organomegaly
palpable

CNS grossly intact

ECG - no new Ab, no ST depression
Impression: ? severe
? angina / MI
? other

Plan: admit
serial CEN/ECG, bloods (as
done in ATE), CXR ^{FBE} ^{MBA}

• TFTs mane

• (N) diet

• routine obs

• notify if further chest
pain / if concerns
start Aspirin 150mg daily
(hold throxene until TFTs)

12.6.95 Pt well. No chest pain. W/Carrolla patient.

2245 Obs satisfactory. 6 red collected.

13.6.95 0400 hrs. Observed to have rested well.

note Frequently checked. 11 files patient.

13/6/95

DR [REDACTED] MR

1 hour of chest pain yesterday -
nil since. No chest pain in
past 2 yrs until now.
Hx of 2 MI's previously
ECG evidence of old anteroseptal
+ inf. MI

thyroid
Ab'sO/EHR 84 BP 110/70 T/P/N/E HS (N)
chest clear

Plan - await CE's
- thyroid Ab
- fasting lipids tomorrow a.m.
- ETT as outpatient
following A/C.

(INTERN)

13-6-95

Pt well, no chest pain, no shortness of breath.

1455

IV cannula patent - intact, site (no redness).

(as per (Held tube broken) Pt to fast 12hrs/
H₂O only for fasting lipids in am. [REDACTED]

13-6-95

Nursing 24hrs. Self-caring. IV cannula patent.

No complaints of chest pain. Fou NBM
from midnight. [REDACTED] MRD

14-6-95

0400 observed to have rested

noche

well - frequently checked. IV cannula patent
N.B.M from 2400 hrs (H₂O only) for fasting
Lipids. [REDACTED] Ca

--ID-----SEX---UR NO--

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OAL

22-04-1934

M

Ph (H)

Ph (B)

CATHOLIC

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
14/6/95	JHO/ [REDACTED]
	LMO - Dr [REDACTED] ([REDACTED] Place) → no longer the G.P. - Dr [REDACTED] [REDACTED] St [REDACTED]

BUNDABERG HEALTH SERVICE
NURSES DISCHARGE SUMMARY

BUNDABERG HEALTH SERVICE NURSES DISCHARGE SUMMARY		YES	N/A
Medications given to patient		✓	
Appointment given to patient			
If yes – Doctor _____ Date _____			✓
Community Support Service			✓
X-rays returned			✓
Valuables returned			✓
Relatives notified		✓	
Transport arranged			
Private ☒ Q.A.S. ☐ (must be a subscriber)		✓	
Letter given to patient			✓
Medical certificate given to patient			✓

SIGNATURE OF REGISTERED NURSE

DATE _____

(Slk No. 7799079)

[illegible]

SURNAME				GIVEN NAMES											
PRN ADMINISTRATION				Date	Time	Sig.	Date	Time	Sig.	Date	Time	Sig.	Date	Time	Sig.
DRUG <i>Mylanta</i>															
ROUTE	DOSE	FREQ.	START												
<i>0</i>	<i>10ml</i>	<i>8⁶PRN</i>	<i>12/6</i>												
DOCTOR			Pharmacist												
DRUG <i>Paracet</i>															
ROUTE	DOSE	FREQ.	START												
<i>0</i>	<i>1g</i>	<i>60</i>	<i>12/6</i>												
DOCTOR			Pharmacist												
DRUG															
ROUTE	DOSE	FREQ.	START												
<i>0</i>															
DOCTOR			Pharmacist												
DRUG															
ROUTE	DOSE	FREQ.	START												
DOCTOR			Pharmacist												

INPATIENT DISCHARGE PRESCRIPTION		
U.R. No.:	D.O.B.	Doctor's Name: (Please Print)
	Wt.:	
Patient's Name: _____		Date
Address: _____		Cas.:
_____		Ward/Clinic:
	Days Reqd	Pharmacy
M.O. SIGNATURE:		

M

NURSING CARE RECORD

MEDICAL DIAGNOSIS Chest pain

Ph (H) [REDACTED]
Ph (B)
CATHOLIC

[illegible]

HOSPITAL

059241

F
22/04/1934

HUSBAND

SUMMARY ON DISCHARGE

(Print Patient Identification Label Here)

A more detailed summary
will be forwarded.

TO: Copy sent to Sister

☐ DOCTORCOPIES SENT
TO:—

No. & STREET

SUBURB POSTCODE

MORE INFORMATION
AVAILABLE FROM
MEDICAL SUPT'S
OFFICE. ALWAYS
QUOTE U.R. No. IN
ALL CORRESPONDENCE.

(1)

(2)

DATE OF ADMISSION: 18.06.93 CONSULTANT:

DATE OF DISCHARGE: 28.06.93 WARD:

DIAGNOSIS AT DISCHARGE ① Inferior MI ② Hypothyroid

③ Raised Cholesterol

PRESENTING COMPLAINTS/CLINICAL FEATURES Chest pain, radiated
into her back SOB nausea

RELEVANT INVESTIGATION RESULTS ECG — TWI inf leads

CE'S	AST	① 48	② 69	③ 75	WBC	9.7
	LDH	207	233	269	Hb	12.8
	CK	635	752	689	Plt	357

TREATMENT/OPERATION patch commenced — removed
due to hypotension 4/38, Continue thyrox

COMPLICATIONS/CLINICAL COURSE AS TFT's revealed hypothyroidism

Start Atenolol & Aspirin & Imdur

* Repeat TFT's in 4/52

MEDICATION ON DISCHARGE Amlinine S/L i prn

Aspirin ̄ 150mg daily

Atenolol ̄ 50mg mane

Imdur ̄ 60mg mane

Thyroxine ̄ 100ug daily

Miconazole top 1 squirt bd 1/52

DISCHARGE/FOLLOW-UP ☐ Other Hospital☐ Care of referring doctor ☐ Nursing Home☐ O.P.D. Clinic ☐ Other

Signature Status JHO

Date 28/6/93

HUSBAND

F
22/04/1934
HUSBAND

HOSPITAL

F
22/04/1934

GENERAL OBSERVATION SHEET

HUSBAND

DATE		18/6/93		19/6/93		20/6/93		21-6-93		22-6-93		23-6-93		24/6	
TIME		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
TEMPERATURE ° C			6/0	6/0	6/0	6/0	6/0	6	6	6/0	6/0	5	9	5	9
PULSE															
BLOOD PRESSURE															
RESPIRATIONS															
BOWELS		10 10 3WTE 7/10 10 10 10													
WEIGHT		67.5kg													
FOETAL HEART															
URINE PROTEIN															
ALBUSTIK															
BOIL															

HOSPITAL

F
22/04/1934

GENERAL OBSERVATION SHEET

, HUSBAND

(Affix Patient Identification Label here)

DATE		25/6/43		26/6		27/6		28/6								
TIME		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	
TEMPERATURE ° C	41.5															
	41															
	40.5															
	40															
	39.5															
	39															
	38.5															
	38															
	37.5															
	37															
	36.5															
	36															
	35.5															
PULSE	260															
	250															
	240															
	230															
	220															
	210															
	200															
	190															
	180															
	170															
	160															
	150															
	140															
BLOOD PRESSURE	130															
	120															
	110															
	100															
	90															
	80															
	70															
	60															
	50															
	40															
	RESPIRATIONS	120														
		115														
		110														
105																
100																
95																
90																
85																
80																
75																
70																
65																
60																
55																
50																
45																
40																
35																
30																
25																
20																
15																
BOWELS		22 T		T												
WEIGHT		67.7 kg		67.7 kg												
FOETAL HEART				67.7 kg												
URINE PROTEIN	ALBUSTIK															
	BOIL															

DAILY FLUID SUMMARY

F
22/04/1934

LY, HUSBAND

[illegible]

SPECIFIC OBSERVATION SHEET

HOSPITAL

F
22/04/1934

HUSBAND

EXAMPLES:

- FINGERS/TOES - Colour, temp, movement, swelling, pain, numbness, Remarks
- URINE - Vol, colour, reaction. SG. Albumen, Blood, sugar, bile, Remarks

OBSERVATIONS RECORDED: URINE ☐ FINGERS/TOES ☐ OTHER

INDICATE OBSERVATIONS IN SEPARATE COLUMNS

DATE	TIME	T	P	R	BP	FO	SO	REMARKS
18/6/93	1850		55	14	127/61	32		New P admitted to ICU. Clo
								chest pain 6/10 in severity between
								shoulder blades. ECG recorded
	1855				119/60			1/2 Anginine given. pain now 1/10
	1900		63	12	96/57	32		pain 1/10 persisting
	1905		62	14	109/57	32		1/2 Anginine repeated. transderm
	1915				108/56			25 applied pain still 1/10 in
								severity
	1930		60	18	113/68	32		Pain 1/10 but getting better. Pain
								remains between shoulder blades
	1945		60	18	117/62	32		Pain now dull ache - no distress.
	2000		62	20	122/63	32		IV Morphine 2.5mg + IV Marolo-
								10 mg given
	2005		61	20	113/53	32		No pain now.
	2020		60	20	104/48	32		NO Cps pain Monitor SR
	2045		68	20	107/56	32		NO Cps pain. Monitor SR.
	2200		55	18	95/52	32		Asleep monitor SR.
	2300		57	14	95/43	32		Asleep monitor SR.
19/6/93	2400		59	10	91/49	32		2nd CE's taken. Testing mil pain
	0100		53	17	94/53	32		Sleeping
	0220		73	12	96/52	32		Mil pain, resting Monitor SR
	0300		59	12	78/36	32		SR sleeping Gt patch removed
	0305				84/38			
	0315				81/38			SB no clo pain. 0208
	0325				83/42			

DATE	TIME	T	P	R	BP	O ₂	SpO ₂	REMARKS
19/6/73	0400		52	15	85/42		32/m	Sleeping
	0500		56	14	99/53		32/m	Sleeping
	0600	36.5	56	14	108/60			no pain 6kg.
					117/60			
	1030	36.5	55	16	110/61		chl	Feeling a little fainter
	1200		70	18			—	Feeling better
	1800		84	24	117/59		—	
	2045	37.3	74	18	121/59			Pain free.
	2255		82	18				Man in SR No cp.
20/6/73	0210		72	29				Resting quietly
								Man in SR No cp.
								Resting quietly.
	0400		66	33				Man in SR lying on @
								Right eyes closed.
	0555	37.3	91	20	116/55		otx	Man in SR No cp.
					108/69		♀	Afraid. wt 67kg.
								Unsteady on feet.
	1000	36.8	71	11	116/59			Pain free
	1400		59	15				
	1800	37	74	16	105/50			Pain free.
	2000		66	16				Pain free. Sponged - no ill effects
	2100	36	63	16	106/51			No % pain. Monitor s/b.
	2300		126	48	120/72			Sleeping monitor - brain tie
								REST - fully reg. w/ no discomfort
	2400		62	16				Monitor SR sleeping.
21/6/73	0200		58	18				Monitor SR sleeping
	0600	36.1	66	18	105/63			MONITOR - SR. No SOB
					111/63			
	1100	36.8	66	17	105/52			Showered. Monitor SR
								Pain free.
	1600		72	18				Mobilising to toilet. Monitor SR

HOSPITAL

PATIENT PROFILE

DATE 18/6/93

TIME 1840

WARD

(Nursing History and Assessment Sheet)

SURNAME: GIVEN NAMES: AGE: 59

CONSULTANT DR M.O. DR P/D MI

KNOWN ALLERGIES (record in red ink) NIL KNOWN

IS PATIENT ON MEDICATIONS? Yes/No

T. P. R. B/P Weight

VITAL SIGNS:

Urinalysis

NURSING OBSERVATIONS

Colour: PINK Skin State: WARM/DRY

Discomfort/Pain: 90 central chest pain 6/10.

Communication Problems: -

Visual Problems: -

Other Problems: -

ORIENTATION

Hospital and Ward Routine explained: ✓

Nursing Personnel: ✓ Doctor's Visit: ✓ Use of 'Call' Buzzer: ✓

VALUABLES

In Trust: To Relatives: Retained by Patient:

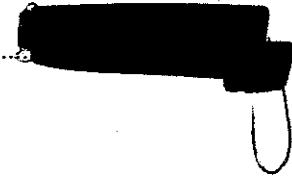
Articles entered into 'Clothes Book': Yes/No

STUDENT OR ENROLLED NURSE'S
SIGNATURE

REGISTERED NURSE'S SIGNATURE:

MR69

0206



.....HOSPITAL



F
22/04/1984

HUSBAND

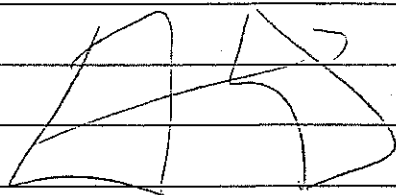
INPATIENT PROGRESS NOTES

(Affix Patient Identification Label Here)

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
18.6.83.	59 y old ♀ pres c th vague chest pain. Began this a.m. Has generally not changed. - better at times. Goes into back. No other radⁿ. no anoxia^{td} to SOB / weakness / ↓LOC. No anoxⁿ i food. Not a i exertion. or ↓ i rest. Has ^{been} just "just not feeling well". Nausea. 1x episode vomiting - water. No Hx URTI / cough. Central chest pain. Vague in nature.
	PM Hx: 4MI 5y ago - no chest pain! CVA^o DM^o angina^o epilepsy^o asthma^o & Hypothyroidism - stopped thyroxine self.
	PS Hx: nil
	Allergis: nil.
	Medicantⁿ: nil.
	C/E: Looks well. A little confused. Intell- oriented.
	PR #0. BP:
	JVP/AE
	Carotids x 2
	AB → x
	HS x 2 —

0205

Chest

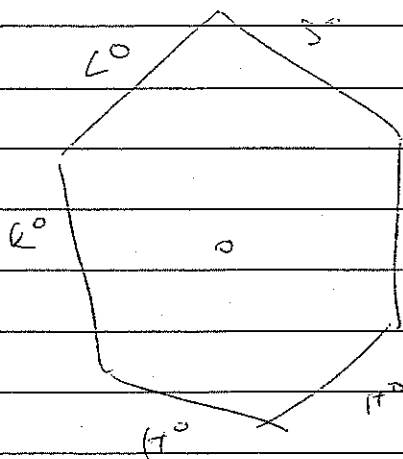


MAD.

AR good

where 'crackles'

Abdo



Soft

no mucus

BS N.

For ECG - no ST Δ.

Q wave infarct ant & inf. ? age.

CE: ↑ CK.

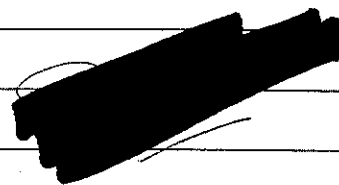
For

FBE ✓

TFT ✓

IV line

admit for obs.



18.06.93

2225hrs: Arrived in ICU @ 1850hrs: P-55 R-14

BP 105/61 G₂-32pm. Cos of chest pain of 10 between shoulder blades: ECG taken.

Analgesic given - 1/2 tit pain decreased to 10.

then to a dull ache. 10 morphine & morphine

given pain ceased. Tolerated light diet &

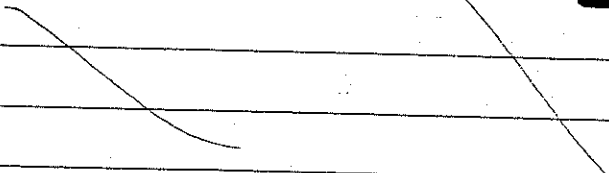
fluids Asleep @ TOR. Voided ✓ - Urine Protein

Ketones. IVB insitu & patent.

F
22/04/1934

HUSBAND

(Affix Patient Identification Label Here)

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
3320	Pain settled A+ keep. ECG - not acute and changes.
	MCA / Parity / hypot / C5. 2/3 } in an- cise
	
19/8/93 0320	ATSP re ↓ BP 25 mg into patch placed on at ~ 2200 BP in A+E 125/61 ↓ gradually to 78/36 patch removed at 0300 BP now 81/38. plan: hypotensive response to transderm patch P: leave off patch
	
	
	0203

19.6.93 0645 CVS:- Monitor SB Rate. S2 - 73. BP 78/36 - $117/60$
No/c/o pain. BP ↓ at 0300hrs 25mg GTN patch removed.

Respi:- No SOB.

Gus:- Passed 500mls urine.

W cannula patent

Fasting lipids done

19/6/93

Very mild ache between shoulder blades.
No central chest pain.

Unstable to tolerate GTN due to hypotension.
No further. 2 heart sounds to bruits.
CK yesterday ↑

For continue monitor today in ICU
Angina ± maybe if pain return
C.T. with aspirin
Monitor today's enzymes
In.

19/6/93
1330hrs

Review - resting quietly. All monitoring

CVS - Monitor SB-SR BP $110/61$ @ 1000hrs.

HR 55-75 Colour pink skin warm & dry

Resp - Nil SOB/dyspnoea. RR 18-20. CXR attended

6TT - tolerating diet Nil nausea

GUS - HPV x 2 - 150mls in total.

IV - Jelic (R) hard.

Psycho/social - visited by husband & son

19/6/93
1600

All CB's raised.

Peak CK 752.

Pain free all day

To stay on ICU

22/04/1934

HUSBAND

(Affix Patient Identification Label Here)

DATE AND STAFF CATEGORY		PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
19/6/93	2005	CAR @ relaxed and watching TV. <u>Psychosocial</u> @ visited by her husband + son. CUS monitor in Sinus Rhythm T IV Jelco patent NO chest pain RRRS SaO2 95% SIT Appetite Fair Oral fluids ^{encouraged} CUS. Output only 270 ml's Nlco @ ROR.
20-6-93	0625	Neuro :- No 46 over night. (87) T° 37.3 at 0600. - Wt 67kgs
RN		CVS :- 66 - 91 BP 116/55 lying 105/69 STAND. - Monitor in SR Reps - Nil Distress GUS - Voided 200 ml's urine. NAD. IV - Cannula flushed + patent
20/6/93		Pain-free. ECG - I-wave inversion all inf. leads. O ₂ /P 80 JVP ↔ Hs 1 - 11 - 1 Chest - few basal creps. → MI protocol. Start Atenolol 25mg Amlod TPTs.

20.6.93 1430hrs ECG attended Afebrile P70-80. Meds
given as charted. IV Cannula flushed & patent.
Dose 2 Carbachol Protocol. Awaiting TFTs - Thyroid
Addit N/I complaints of pain/tightness - [redacted]

20.6.93 2100.
CNS: Pain free evening. Sponged self in no
ill effects.
CUS: Monitor SR-SB. Rate 60-74. BP: 105/50.
Afebrile. Colour pink. Skin warm & dry.
RS: Resps. full & even.

21.6.93 0620 CNS:- Pain free. Sleeping most of the night
CUS:- Monitored in SR-SB 58-66 BP 105/63
Lying 111/63 standing. Afebrile
Resp:- No SOB.
GUS: Urine output 900 mls for 24 hrs

21.6.93 [redacted] WR
Well
Obs Stable BP 110/70
Pn for long duration
CK peak 752 CKMB 24
LDH 270
Chest clear. R 60
for LDH today.
To ward 10.

Prob of infect.

Swab under breast. - Start microscopy - ? Nystatin
with prob results.

[REDACTED]

.....HOSPITAL

[REDACTED]

F
22/04/1984

HUSBAND [REDACTED]

INPATIENT PROGRESS NOTES

(Affix Patient Identification Label Here)

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
21/6/93- BA 1410 HRS	NEURO: Showed self - no epd SOB or chest pain. CVS: Monitor SR HR 54-62. BP ¹⁰⁵ / ₅₂ . Atrial fibrill. RESP: No SOB. GIT: Tolerating Healthy Heart diet GUS: Voiding good volumes. IV: Jelco patent. [REDACTED] (R).
21/6/93 1730.	CNS: Pain free - mobilising to toilet is no ill effects. CVS: Monitor SR. ¹⁰⁰ / ₅₅ Rate 68-72. BP: ¹⁰⁰ / ₅₅ Colour pink. Skin warm & dry. RS: Nil resp. distress. No O ₂ needed. GIT: Tolerating h. heart diet. GUS: VIT x 2 today. IV Jelco in situ (R) arm. SWAB taken Breast - commenced on topical cream at 1600 etc Transferred to Ward 10 @ 1730 [REDACTED]
21.6.93 0805hr	At resting in bed. Administered x 1 to consultant tablet & experienced slight tightness in chest but went away when she returned to bed. At 0840 - instructed to ask for pain over night. Had further episode of chest pain. IV cannula patent. [REDACTED]
22/6/93	0840hrs rested quietly during the night. Nil SOB / chest pain. Wound infiltrated & used [REDACTED]

65/6/93
0600hrs

Admit. Pt stated she had mobilized to
toilet x 21% no problems — [REDACTED]

22-6-93

Dry Report - Comfortable day n/s
mobilizing as per programme.
JELCO Patient. Also stable
appetite food
no pain or SOB as attending to
ADL'S.

22.6.93

Visited by family. [REDACTED]

2245

Pt mobilizing as per regime No chest
pain. IV cannula patent. [REDACTED]

23/6/93

0500hrs Resting quietly overnight. not c/p
pain or SOB. Pt appears patent [REDACTED]

23.6.93

TFT	30	0.35	0.3 - 48
T4	50		60-150
STI	18		20-72
TSH	45		<5

→ hothyroid
[REDACTED]

23-6-93

Dry Report - Comfortable day n/s.
Ictericed 5mm warts with no ill effects.
JELCO infiltrated & removed at 1200hrs.
Visited by family. [REDACTED]

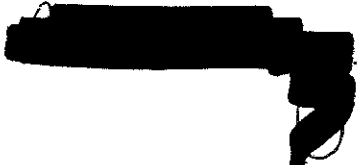
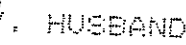
23-6-93.

E/R.

2150hrs - Patient remained mainly
at Bed Rest this shift - ambulating
to toilet - No SOB this shift -
or n/c pain this shift - [REDACTED] (REV)

24.6.93

0430hrs Rested for long periods. On Day 5
of MI Regime today - [REDACTED]

.....HOSPITAL  F 22/04/1934  HUSBAND	
INPATIENT PROGRESS NOTES	
DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
24.6.93	thyroxine - start thyroxine 100mcg Daily Dietry advice from dietitian Enzymes confirm small MI No sign ECG change Post Cardiac post MI Rehab ? Home Sun / Mon
24.06.93	R has been RIB this shift; 1530hrs mobilized around ward - assistance, has had n/c of chest pain or SOB, has mainly been self caring
24/06/93	Ambulant around ward area only cardiac walk. not attended this shift due to business of ward. No complaints pain or SOB.
25.6.93	0430hrs Awake to void only, no other.
25.6.93	Chest pain on mobilization No sign LUF BP 140/60 P 60 Pain relieved O ₂ at LTN Add 1ml but 60mcg Daily Try to achieve once daily regime ? Home Sunday? Mon Sub max evening ECG Next week.

0197

25/6/93 1515.

Independent with nil problems taken for walk
as per cardiac Regime (Up & down 2 flights stairs &
around carpark etc. On return to ward complained
of tightness in neck & across chest O₂ applied @ 6 L/min
via face mask. ECG attended. Tightness ceased
 whilst ECG being taken. O₂ ceased
No further problems this shift. Pt has remained RIB not
moving very much.

cardiac tapes & recorder given to pt but not listened
on as yet.

OT requested to see pt prior to discharge.

25/06/93

Good evening. Mobilized (including
stairs) according to cardiac Regime
& no ill effects. Also started watching
football on T.V. at present.

26.6.93

at 30hrs Rested well overnight, nil ill
effects when awake to ward. OK

26/06/93

1330hrs. Good day. Mobilized according
to cardiac regime & no ill effects.
E.C.G. all ok.

26/06/93 2200hrs

Quiet evening spent mainly RIB watching T.V. cardiac
walk attended with nil problems (Talking and walking)
Pt has not listened to the cardiac tapes - reluctant to
do so late this pm due to T.V. Programmes Encouraged
to do so this pm in the am.

27.6.93

at 30hrs. Rested well overnight.

27-6-93

O/R 1300hrs pt walked for 15 min -
including stairs, no ill effects noted
or voiced. sleeping at time of report
pt Encouraged to listen to tapes.

27/6/93 2125

Pt has spent shift mainly RIB watching T.V.
cardiac tapes listened to & cardiac literature
given.

F
22/04/1994

HUSBAND

INPATIENT PROGRESS NOTES

(Affix Patient Identification Label Here)

DATE AND STAFF CATEGORY		PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT	
28.6.93	et/hrs	Rested well, had no overnight	
28.6.93	Dr [redacted] we	Int ms.	
		No pyrexia, tachol.	
		Past Hx ms 5 yrs ago	
		OPD Dr Finn 6/52	
		Rpt TET 4/52	
		[redacted]	
		Aspirin 31L - one	
		Isoprin 0 150mg daily	
		Atenolol 0 50mg mane	
		Indur 0 60mg mane	
		Thyroxine 0 30mg daily	
		Mitondazole 0 10mg bid	
28/6/93	O/R	A discharged to home	

SURNAME

GIVEN NAMES

PRN ADMINISTRATION

Date Time Sig. Date Time Sig. Date Time Sig. Date Time Sig. Date Time Sig.

DRUG

Ponadaf

ROUTE DOSE FREQ. START

O 1g q4h 18/6

DOCTOR Pharmacist

DRUG

Angin

ROUTE DOSE FREQ. START

51 1/2-1 new 18/6

DOCTOR Pharmacist

DRUG

Morphine

ROUTE DOSE FREQ. START

iv 25mg new 18/6

DOCTOR Pharmacist

DRUG

maxib

ROUTE DOSE FREQ. START

iv 10mg q4h 18/6

DOCTOR Pharmacist

INPATIENT DISCHARGE PRESCRIPTION

U.R. No.:

D.O.B.

Wt.:

Doctor's Name: (Please Print)

Patient's Name: _____

Date

Address: _____

Cas.:

Ward/Clinic:

Days
Reqd

Pharmacy

M.O. SIGNATURE: _____

F
22/04/1934

Y, HUSBAND

DATE	SURGICAL/MEDICAL PROCEDURES	DATE	SPECIAL INSTRUCTIONS
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8/6/93 1V Jelco (R) hand

23/13 + V Removed.

26/6 ECG please

22/10/10 TFR = 6.4 BD

22/1 6.5 BP 0600

02/6	Daily Weigh deco
------	------------------

27/6	Listen to Cardiac Tapes
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DATE	SPECIAL NEEDS
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PHYSIO

SOCIAL WORKER

DATE	PATHOLOGY/X-RAY REQUESTS
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18/6/93	CxP
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CE X 207 ✓

FBL UTE CEX3

CEX 3

76/6 E.e.G.

OCCUP. THERAPY

OTHERS

DATE	DIET
------	------

6/6/93	H. Heath
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0192

Consultant *Ali*P.H.O. *Dr*

Ward

ADMISSION DATE *18/6/03*DISCHARGE DATE *28/6/03*F
22/04/1934

HUSBAND

Address

Religion

Relatives contacted re Transfer: YES / NO

Name

Discharge to *Home*

Phone No.

Transport:

Private ☐Ambulance ☐

Ambulance Subscriber: YES / NO

ALLERGIES

DIET (HELP/FEED)

MOBILITY

WALKING AIDS ☐

PERSONAL HYGIENE

DENTURES: UPPER ☐LOWER ☐

PRESSURE AREA CARE

ELIMINATION

DRESSINGS

VISION

GLASSES ☐C/LENS ☐PROSTHESIS ☐

HEARING

HEARING AID ☐

COMMUNICATION

VALUABLES

WALLET ☐RINGS ☐WATCH ☐OTHER ☐

HOME ENVIRONMENT

HOUSE ☐HIGH ☐LOW ☐No. OF STAIRS ☐FLAT/VAN ☐HIGH ☐LOW ☐No. OF STAIRS ☐CARAVAN ☐

MEDICATIONS

APPOINTMENTS

LETTER/REFERRAL