Ex 184

SURNAME ____________

GIVEN NAMES ____ P111

UNIT RECORD NUMBER

DECEASED

last attendance	
1993	
94	
97	
00	
02	
03	
2004	

CONFIDENTIAL
Medical Records may not be removed from this hospital

IDENTIFICATION SHEET

MEDICARE NUMBER U.R. No.

SURNAME

GIVEN NAMES P 111

DATE OF BIRTH SEX Male ☐ Female ☑

ADDRESS

PHONE No. WORK

OCCUPATION

ETHNIC ORIGIN Caucasian ☐ Aboriginal ☐ T.S.I. ☐ Other ☐

MARITAL STATUS Single ☐ Married ☑ Widowed ☐ Divorced ☐

RELIGION

NEXT OF KIN

SURNAME GIVEN NAMES

RELATIONSHIP PHONE No WORK

ADDRESS

HEALTH INSURANCE FUND

PENSION No.	REPAT No.
BLOOD GROUP	LMO
IMMUNIZATIONS	ADDRESS
YEAR / TYPE	TELEPHONE:
	LMO
	ADDRESS
	TELEPHONE:
	LMO
	ADDRESS
	TELEPHONE:

ALLERGIES AND DRUG REACTIONS:

NIL KNOWN

124470 -I-059—Govt. Printer. Qld.

BUNDABERG BASE HOSPITAL

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

P111

Ph(H)
Ph(B)

EMERGENCY RECORDS

BUNDABERG HOSPITAL EMERGENCY RECORD

00 01

Surname	Given Name	Date of Birth	Sex
Pill			F

Patient No:	Emerg. No:	Arrival Date and Time

Triage Cat	Area	Complaint
2	R1	CHEST PAIN

Allergies:- NKA

Immunisation Status:-

Triage Notes Developed central chest pain 5/10 @ 0330hr - radiating up to jaw and through to her back - Called ambulance - who state pain was 5/10 O/A -> gave client ½ Anginine ½ Aspirin ↓ pain to 0/10. Completely pain free O/A to DEM.

TRIAGE RN Printed Name/Stamp L Bray Signature L Bray

TIME	T	P	R	BP	O2	SAO²	GCS	PAIN SCALE (1-10)
		Refer [illegible]						

NURSING NOTES

ID:________________
12-01-03 6:20AM
CLARITY: __________
COLOR: LT. YELLOW
GLU NEGATIVE
BIL NEGATIVE
KET NEGATIVE
SG 1.010
BLO NEGATIVE
pH 5.5
PRO NEGATIVE
URO 0.2 E.U./dL
NIT [illegible]
LEU

WARD TEST URINE:-

WEIGHT:-

MEDICATION ORDERS

DATE	TIME	DRUG	DOSE	ROUTE	M.O.	GIVEN BY	TIME GIVEN

00 02 69/F

MEDICAL HISTORY, EXAMINATION, TREATMENT AND FOLLOW-UP

DATE/TIME	
07/12/03 0458	C/C Chest pain - 2hr 30min
	Hx
	Spontaneous chest pain (dull) at rest. Pain was
5/5/06	5/10, Persistent pain, radiates to jaws & shoulder
	Pain lasted for 30min. No nausea, No vomiting
	No SOB. She has been having recurrent
	chest pain in last few days. Chest pain/oppression
	whenever she does any strenuous activity. Pain
	now relieved by x1 GTN spray/Aspirin
	Past hx — Drug hx
	MI - 93/95 — Thyroxin
	Thyroid disease - on Thyroxine. — GTN spray.
	(E) Not in distress Pain 0/10 BP 125/94 Pulse 80/min
	Resp 20/min pulse. wt 68.2 Kg.
	Resp Trachea central. — CVS 0 cyanosis
	Equal chest movement — 0 JVP
	good AE, base crepts + — 0 heave 0 thrills
	2HS, No murmur, 0 oedema.
	ABD [abdominal diagram] soft, ouless
	Opinion MI to exclude
	DDx Angina
	(P) ⇒ FBC/UEC/LFT/CK/Troponin/TFT
	→ CXR
	→ O2 at 6L/min — ws
0558	

ADMISSION CHECKLIST	PROCEDURES	PATIENT DISCHARGE INFORMATION
Medical Order Sheets:	IV Cunnula ____ gsite ____	Ward ____
Medication ☐	IV Fluids in Progress ☐	Speciality ____
Fluids ☐	Bloods ☐ MSU ☐	Discharge Date ____
Fluid Balance Chart ☐	ABG's ☐	Time ____
XRay ☐	NGT ☐ ____ g	APPT ☐ Department ____
Property List ☐	IDC ____ g ____ ml	Date ____
Relatives Notified	O^2 Therapy ____ Lpm	
Armband ☐	via ____	
Protocols ☐	Dressing/Suture Site: ____	

IN CARE OF ☐ RELATIVE ☐ FRIEND ☐ SELF ☐ — RN Signature:

AFTER CARE INSTRUCTIONS GIVEN ☐ Use of crutches ☐ Plaster Care ☐ Head Injury

BUNDABERG HOSPITAL EMERGENCY RECORD

-0343

00 03

Surname	Given Name	Date of Birth	Sex
P111			F
Patient No:	**Emerg. No:**	**Arrival Date and Time**	

Triage Cat	Area	Complaint
3	A ~~WR~~	R UPPER BACK PAIN

Allergies:- NIL KNOWN.

Immunisation Status:-

Triage Notes Pain since 2200 hrs Vomited x ii Not short of breath. Colour - Pink skin - Warm + dry. Speech appropriate No known injury.

TRIAGE RN Printed Name/Stamp McKEON Signature [signature]

TIME	T	P	R	BP	O2	SAO²	GCS	PAIN SCALE (1-10)	NURSING NOTES

~~see MR 62~~

WARD TEST URINE:- SG 1005, +++ protien pH 6.0 WEIGHT:-

MEDICATION ORDERS

DATE	TIME	DRUG	DOSE	ROUTE	M.O.	GIVEN BY	TIME GIVEN
19/9/2002	03:45	Nurofen Susp.	20ml	P.O.	[signature]	[signature]	0345
19/9/2002	04.10	Anginine	300µgm	S.L	[signature]	[signature]	0415
19/9/2002	04.15	Morphine	2.5mg	I/V	[signature]	[signature]	0420
19/9/2002	04.15	Maxolon	10mg	I/V	[signature]	[signature]	0419

MR4

MEDICAL HISTORY, EXAMINATION, TREATMENT AND FOLLOW-UP

DATE/TIME	
19/9/2002	
03:30	PIII ♀
(MIN)	was brought to DEM by QAS
	with H/o sudden onset of pain
	in the rt. side of back at about
	10.00 PM last night. NO S.O.B, naesialip
	Pain is localised and not radiating.
	Taken Anpanon 2tabs at home
	Past Medical History of - MI, Hypothyroidism.
	Medication: Oroxin 100 ugm.
	Personal Habit. NO smoking, not drinking.
(M54.6)	
	Allergy: Nil known.
	O/E. G. condition - good GCS 15
	Afebrile.
	Resp. System. lungs clear
	VBS all over, no crepitation.
	RR 20 /min O2 sat 98%.
	Heart: Both sounds heard
	BP 185/88 mmHg.
	PR 68 /min
	Abdomen. soft.
	Liver & spleen not palpable
	Bowel sound (+)

ADMISSION CHECKLIST	PROCEDURES	PATIENT DISCHARGE INFORMATION
Medical Order Sheets:	IV Cunnula ____ gsite ____	Ward ________
Medication ☐	IV Fluids in Progress ☐	Speciality DEM
Fluids ☐	Bloods ☐ MSU ☐	Discharge Date 19/9/2002
Fluid Balance Chart ☐	ABG's ☐	Time 05:20
XRay ☐	NGT ☐ ____ g	APPT ☐ Department ________
Property List ☐	IDC ____ g ____ ml	Date ________
Relatives Notified	O² Therapy ____ Lpm	
Armband ☐	via ________	
Protocols ☐	Dressing/Suture Site: ____	

IN CARE OF ☐ RELATIVE ☐ FRIEND ☐ SELF — RN Signature:

AFTER CARE INSTRUCTIONS GIVEN ☐ Use of crutches ☐ Plaster Care ☐ Head Injury

Bundaberg Hospital

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

P111

CONTINUATION SHEET

Ph(H)
Ph(B)

DATE AND TIME	HISTORY, EXAMINATION AND TREATMENT
	Extremities: no pedal oedema.
	CNS. Intact
	Impression: Musculo-skeletal Pain (R) Back.
	Plan. I/V Canula access
	Nurofen Syrup. 20ml
	Anpirene 300 gm.
LD 289↑	I/V Morphine 2.5mg
CK 210↑	I/V Maxolon 10mg
cTNT. ND	Blood MBA, LFT, CK, Troponin
CRP 6.2↑	CRP. Coags. D. Dimer FBC.
WCC 9400 D. Dimer <1	ECG. no new changes.

ACCIDENT & EMERGENCY / OUTPATIENT CONTINUATION SHEET

GOPRINT©

MR5

00 06

Bundaberg HOSPITAL

Bundaberg Hospital

SEX UR NO

P111

SPECIFIC OBSERVATION SHEET

Ph (H)
Ph (B)

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		O2	SATS		Pain	REMARKS (R auxilla - back pain)
	0330	36.7	71	24	189/93		RA	99%		5/10	ECG bloods/IV
	0350		65	24	181/89		RA	98%		6/10	brufen 400mgs
	0355		60	24	181/90		6l	99%			
	0400		65	24	169/90		6l	99%		6/10	BSL 6.7 mmols
	0410		66	24	185/88		6l	99%		6/10	300mcg anginine
	0415	rpt ECG								6/10	post anginine
	0420	10mgs maxalon, 2.5mgs morphine									
	0421		63	20	131/86		6l	98%		1/10	+++ protein u/A.
	0440		68	20	135/81		6l	99%		2/10	
	0500		65	20	149/90		6l	99%		2/10	

SPECIFIC OBSERVATION SHEET

BUNDABERG HOSPITAL EMERGENCY RECORD

00 07

Surname	Given Name	Date of Birth	Sex
P111			
Patient No:	**Emerg. No:**	**Arrival Date and Time**	
(			

Triage Cat	Area	Complaint
5	WR	PAINFUL L FOOT

Allergies:- N/K

Immunisation Status:-

Triage Notes Patient complaining of painful (L) foot 2/7. No known injury. Previous episode 2/12 ago & saw GP. [signature]

TRIAGE RN Printed Name/Stamp J WILSON RN Signature

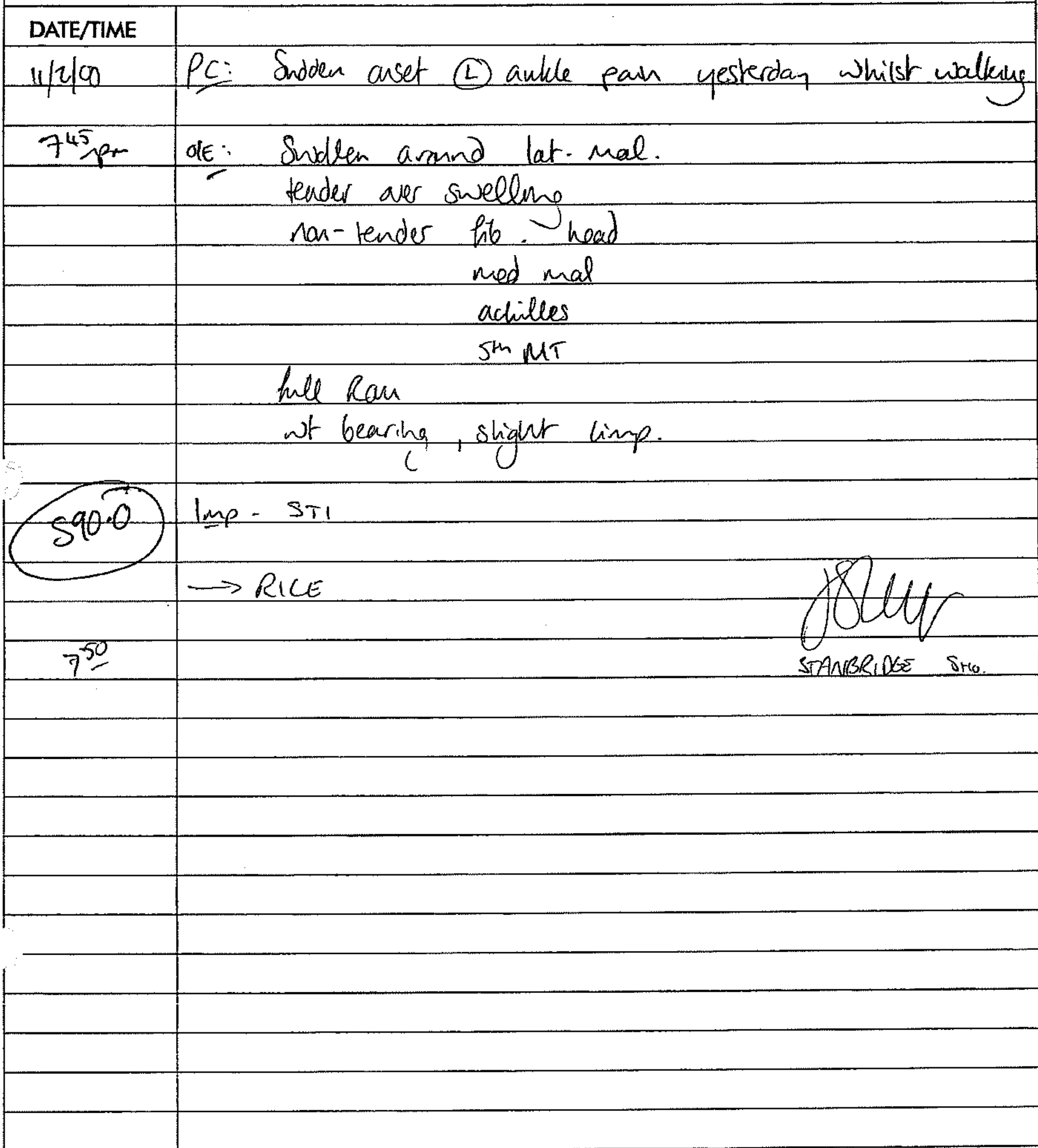
TIME	T	P	R	BP	O2	SAO²	GCS	PAIN SCALE (1-10)	NURSING NOTES

WARD TEST URINE:- **WEIGHT:-**

MEDICATION ORDERS

DATE	TIME	DRUG	DOSE	ROUTE	M.O.	GIVEN BY	TIME GIVEN

MEDICAL HISTORY, EXAMINATION, TREATMENT AND FOLLOW-UP



DATE/TIME	
11/2/90	PC: Sudden onset (L) ankle pain yesterday whilst walking
7⁴⁵ pm	o/E: Swollen around lat. mal.
	tender over swelling
	non-tender fib. head
	med mal
	achilles
	5th MT
	full Rom
	wt bearing, slight limp.
S90.0	Imp - STI
	→ RICE
7⁵⁰	[signature] STANBRIDGE SHO.

ADMISSION CHECKLIST	PROCEDURES	PATIENT DISCHARGE INFORMATION
Medical Order Sheets:	IV Cunnula ____ gsite ____	Ward ____
Medication ☐	IV Fluids in Progress ☐	Speciality ____
Fluids ☐	Bloods ☐ MSU ☐	Discharge Date ____
Fluid Balance Chart ☐	ABG's ☐	Time ____
XRay ☐	NGT ☐ ____ g	APPT ☐ Department ____
Property List ☐	IDC ____ g ____ ml	Date ____
Relatives Notified	O^2 Therapy ____ Lpm	
Armband ☐	via ____	
Protocols ☐	Dressing/Suture Site: ____	

IN CARE OF ☐ RELATIVE ☐ FRIEND ☐ SELF | RN Signature:

AFTER CARE INSTRUCTIONS GIVEN ☐ Use of crutches ☐ Plaster Care ☐ Head Injury

BUNDABERG HOSPITAL EMERGENCY RECORD

00 09

Surname	Given Name	Date of Birth	Sex
P111			

Patient No:	Emerg. No:	Arrival Date and Time

Triage Cat	Area	Complaint
4	WR	FB R EYE

Allergies:- N/K.

Immunisation Status:-

Triage Notes In the park yesterday ? FB R eye
Been sore ever since

TRIAGE RN Printed Name/Stamp N. Friar Signature [signature]

TIME	T	P	R	BP	O2	SAO²	GCS	PAIN SCALE (1-10)	NURSING NOTES

WARD TEST URINE:- **WEIGHT:-**

MEDICATION ORDERS

DATE	TIME	DRUG	DOSE	ROUTE	M.O.	GIVEN BY	TIME GIVEN

MEDICAL HISTORY, EXAMINATION, TREATMENT AND FOLLOW-UP

DATE/TIME	
22/9/97 12:15	in the park yesterday → felt FB in eye
	→ O/Ex – grit under eyelid
	– removed with cotton bud
	++ improved.
	[signature]

ADMISSION CHECKLIST	PROCEDURES	PATIENT DISCHARGE INFORMATION
Medical Order Sheets:	IV Cunnula ____ gsite ____	Ward ________
Medication ☐	IV Fluids in Progress ☐	Speciality ________
Fluids ☐	Bloods ☐ MSU ☐	Discharge Date ________
Fluid Balance Chart ☐	ABG's ☐	Time ________
XRay ☐	NGT ☐ ____ g	APPT ☐ Department ________
Property List ☐	IDC ____ g ____ ml	Date ________
Relatives Notified	O^2 Therapy ____ Lpm	
Armband ☐	via ________	
Protocols ☐	Dressing/Suture Site: ____	

IN CARE OF ☐ RELATIVE ☐ FRIEND ☐ SELF　RN Signature:

AFTER CARE INSTRUCTIONS GIVEN ☐ Use of crutches ☐ Plaster Care ☐ Head Injury

PATIENT DETAILS

Wide Bay Region
Bundaberg Hospital
EMERGENCY RECORD

00 11

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

P111

Ph (H)
Ph (B)

TRIAGE CAT.	1	(2)	3	4	5

Mode of Arrival:
- QAS [ ]
- Police [ ]
- Self [✓]
- Other ______ [ ]

Presentation Source:
- Hospital [ ]
- LMO [ ]
- Review [ ]
- Revisit [ ]
- Self [✓]
- Other ______ [ ]

Date of Injury ....
Place of Injury ....
Mechanism Injury ....
Last ADT date ....
Allergies ... NK.

TRIAGE: Date 12/6/95 Time 1200 Departure Date........ Time........hrs

Presenting Complaint: c/o Burning type chest pain. Vomited x 1. Pain sudden onset ≈ 1/2/24 ago. 8/10 now o/A 2/10. Hx MI 2 yrs ago. ECG ✓. c/o right chest.

TRIAGE RN Printed Name/Stamp........ Signature........

Time	T	P	R	BP	02 Sat	Comments
1200		61	18	129/T	98% RA:	ECG attended
1215		57	18	122/65		Painfree - slight pain between shoulder blades
[illegible]						

Height........ Weight........ Urinalysis........

ONCE ONLY (AND PREMEDICATION) DRUGS / INTRAVENOUS FLUIDS

Time	Fluid/Drug	Dose/Rate	Route	Doctor	Given by	Time Given
12/6	Mylanta	20ml	O	[signature]	[signature]	1225

(Continued over page)

Emergency Record

MEDICAL HISTORY, EXAMINATION, TREATMENT AND FOLLOW-UP

DATE/TIME	
12/06/95	IV Cannula inserted 20G. Flushed c n'saline
1240.	Bloods collected. Pt remains painfree.
	For admission to Wd 10. — [signature]

Discharge Date............................ Time.............................

DESTINATION	OT	ICU	WARD 10 (circled)	CT SCAN	OTHER SPECIFY
OUTCOME	ADM (circled)	DIS	TRANS	REFER	

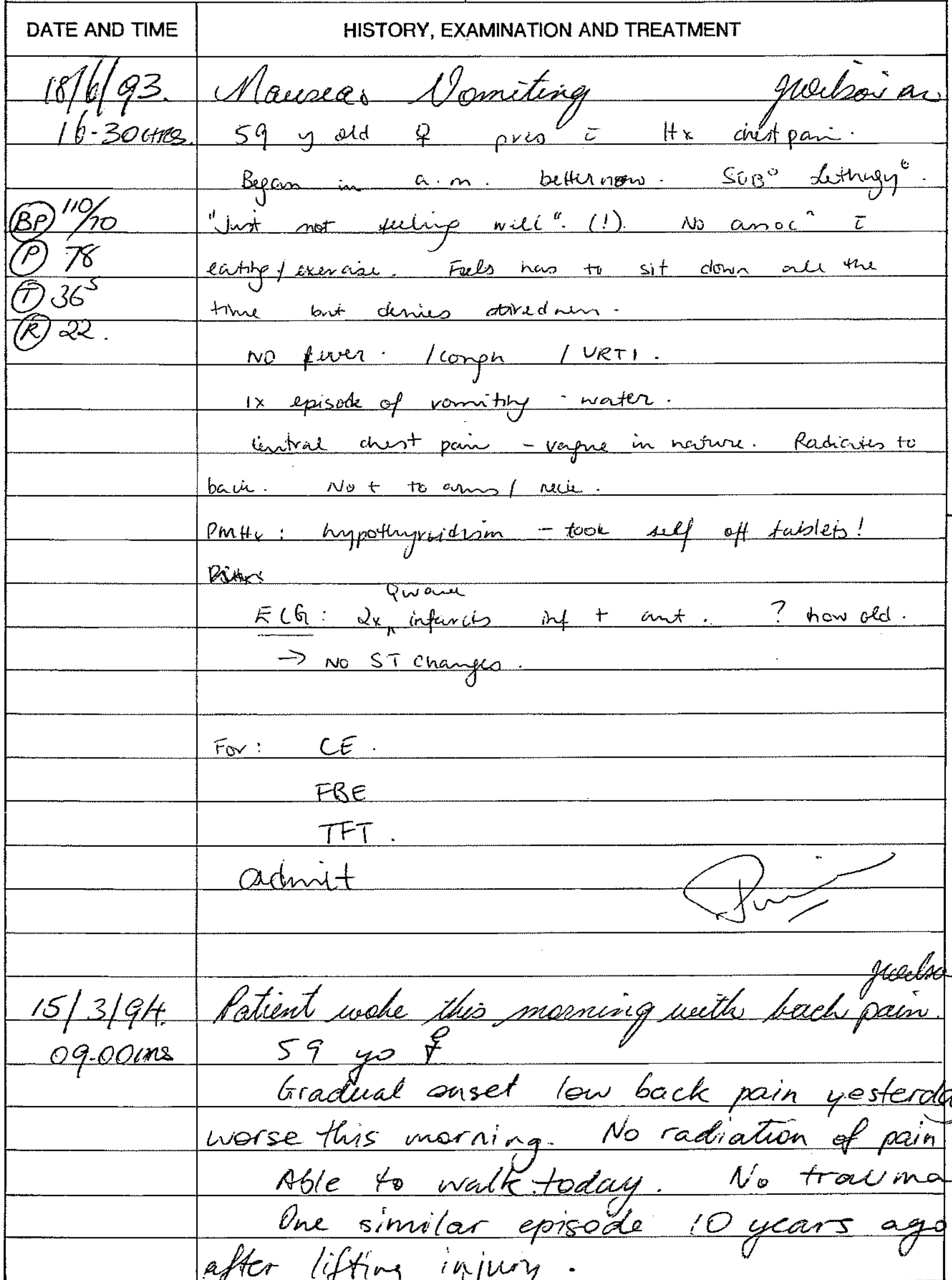
SPECIALTY ADMITTED UNDER	MED (circled)	SURG	ORTH	GYN	OBS	PAED	OTHER SPECIFY

Bundaberg Hospital

00 13

P111

CONTINUATION SHEET



DATE AND TIME	HISTORY, EXAMINATION AND TREATMENT
18/6/93.	Nausea Vomiting Jackson ac
16-30 HRS.	59 y old ♀ pres c̄ Hx chest pain.
	Began in a.m. better now. SOB° Lethargy°.
(BP) 110/70	"Just not feeling well". (!). No assoc^n c̄
(P) 78	eating / exercise. Feels has to sit down all the
(T) 36⁵	time but denies tiredness.
(R) 22.	
	No fever. / cough / URTI.
	1x episode of vomiting - water.
	Central chest pain - vague in nature. Radiates to
	back. Not to arms / neck.
	PMHx: hypothyroidism - took self off tablets!
	~~PHx~~
	ECG: 2x Q wave infarcts inf + ant. ? how old.
	→ No ST changes.
	For: CE.
	FBE
	TFT.
	admit [illegible signature]
	[illegible signature]
15/3/94.	Patient woke this morning with back pain.
09.00 HRS	59 yo ♀
	Gradual onset low back pain yesterday
	worse this morning. No radiation of pain
	Able to walk today. No trauma
	One similar episode 10 years ago
	after lifting injury.

ACCIDENT & EMERGENCY / OUTPATIENT CONTINUATION SHEET

MR5

DATE AND TIME	HISTORY, EXAMINATION AND TREATMENT
	o/E not distressed
	tender to (L) of L2-3 (T.P.s)
	paraspinal mm. nontender
	tone }
	power }
	reflexes } (N) LLs.
	sensation }
	XR L-S spine : osteoarthritic changes
	esp. L1-2 with slight subluxation
	of L2 forward on L1. no # seen.
	no C/I to NSAIDs
	P/ home
	rest, Naprosyn
	physio referral [signature]

BUNDABERG BASE HOSPITAL

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

P111

Ph(H)
Ph(B)

SPECIALIST OUTPATIENT RECORDS

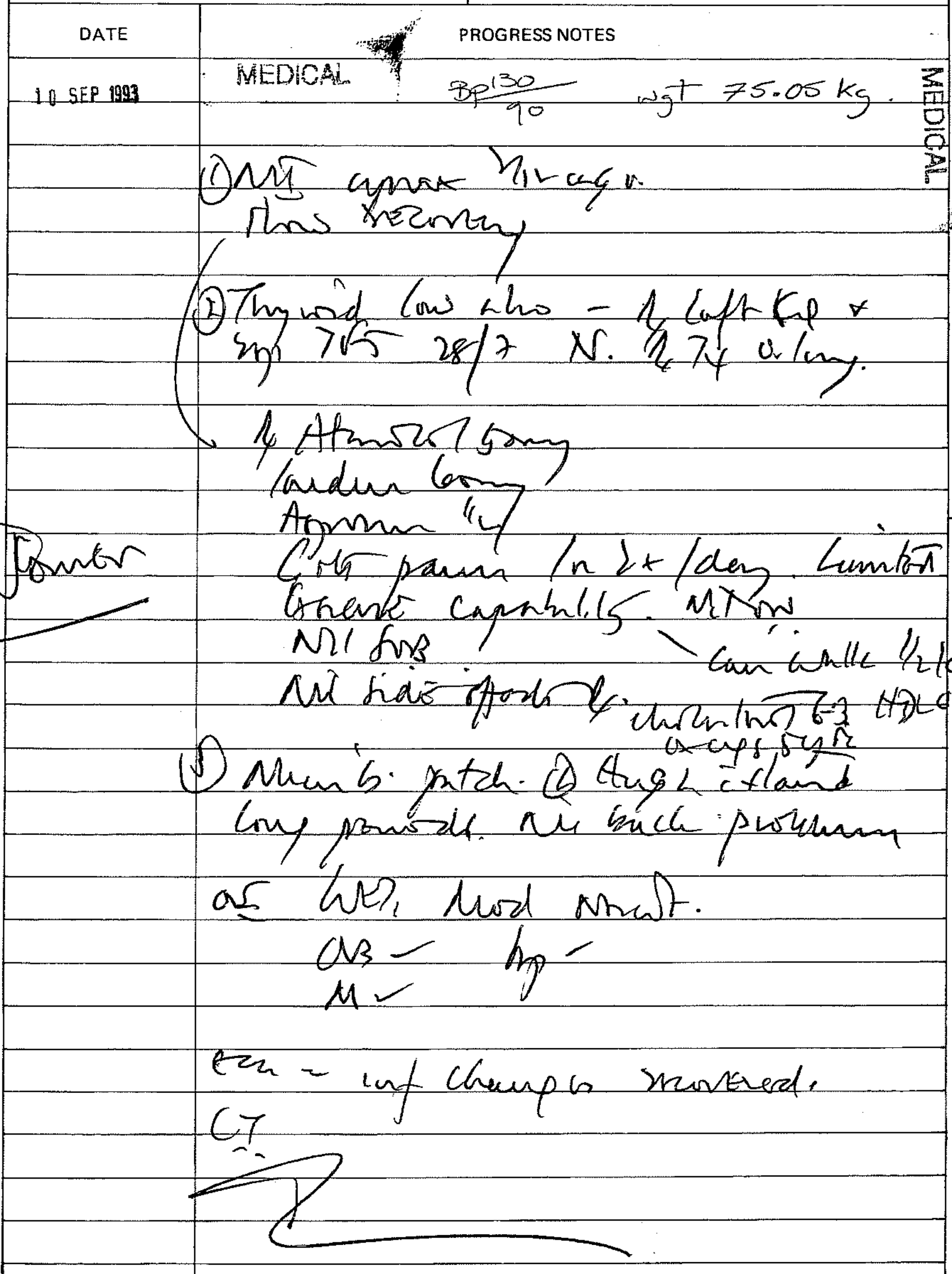
Bundaberg HOSPITAL

00 15

P111

OUTPATIENT NOTES

DATE	PROGRESS NOTES
10 SEP 1993	MEDICAL BP 130/90 wgt 75.05 kg.



MEDICAL

SPECIALIST OUTPATIENT NOTES

00 16

B'berle HOSPITAL

PHYSIOTHERAPY RECORD

Surname P111 U.R. No.

Given Names

Sex D.O.B.

(Affix Patient Identification Label Here)

ADDRESS

TELEPHONE: Home Work

OCCUPATION DR WHITTINGHAM DATE REFERRED 15·3·94

M.O. WARD OUTS.

DR. APPOINTMENT NO PRIOR ATTENDANCES

COMPENSATION BENEFITS NO HEALTH INSURANCE Y (N)

CONDITION FOR WHICH REFERRED SPECIFIC DIAGNOSIS HCC (Y)

REQUEST

CARDIAC PACEMAKER: YES (NO)

OTHER PRECAUTIONS:

DATE	ASSESSMENT AND TREATMENT
24·3·94	
	with insidious onset
	of LBP 14/3/94.
	G-H – angina
	Meds: anginine
	Wt stable.
	XR: OA L1-2
	[Naprosyn ceased]
	O/E:
	Large abdomen
	ROM Lx-Sx sp.
	F ✓✓ LF (L) ✓✓
	E ✓✓ (R) ✓✓
	C ✓✓ ↺ ✓✓
	O/P ↓ L1 → S1 III ✓✓
	Given mobility +
	strengthening ex. program
	D/C

constant dull ache. for 5/7 Nil now.

✓✓ ✓✓

✓✓ ✓✓

P&N°

N°.

✓✓ ✓✓

T. Wallace

CONNELLY DOREEN 055924

PHYSIOTHERAPY RECORD