BUNDABERG BASE HOSPITAL

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

P111

Ph(H)
Ph(B)

ADMISSION RECORDS

ADMISSION DATE

1/12/03

Bundaberg Hospital SEX UR NO

BUNDABERG HEALTH SERVICE DISTF

Queensland Government

CLINICAL SUMMARY

Pill

Usual GP..... Ph (H).

Address ..... Ph (B)

Burrum St Med.

Admission Date:	Discharge Date:	Follow-up Clinic:	Referral:
1/12/03	2/12/03	PHO	

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)
- ☐ Chest infection
- ☐ Haemorrhage/haematoma
- ☐ Pulmonary embolism
- ☐ Urinary tract infection (include organism)
- ☐ Adverse drug reaction
- ☐ DVT
- ☐ Others (please specify below)

External Cause of Injury/Poisoning:

Clinical Course and Significant Results:

Unstable angina / Non ST↑ MI

Yes typed letter

Enclosed by Mail

Abnormal results

- ☐ ECG
- ☐ Radiology reports
- ☐ Haematology
- ☐ Histopathology
- ☐ MBA20
- ☐ Other

DISCHARGE MEDICATION/DOSAGE:

Thyroxine 100 mcg 1

Aspirin 100mg 1

Lipitor 20mg 1

Lasix 40mg 1

DISCHARGE MEDICATION/DOSAGE:

MO Signature: **Print name:** DSHOKMAN

Designation: PHO **Date:** 2/12/03

Consultant: Graham

00 69 MR53

BUNDABERG BASE HOSPITAL

00 70

- P111

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

Abid Khan
Med PHO
4152 1222

BUNDABERG [illegible]

UR 00 7[illegible]

PUBLIC

Title	Surname	Given Names	Date of Birth	Age
	Pitt			

Address

Sex	M.S.	Country of Birth	Religion

Ethnic Origin

OR ONLY

Telephone - Home	Telephone - Business	Occupation (Current or Last)

First Contact

Alternative Contact

If discharged in last 7 days, from which hospital	Date Admitted	Time Admitted	Admission Source
	01 Dec 2003	06:00	A & E

Referring Doctor/Person

DR B HARTLEY
BURRUM STREET

BUNDABERG 4670

Unit	Ward	Bed	Treating Doctor
MED	10		STRAHAN

Account Class	Health Fund	Health [illegible]
GPE		

Medicare Number | Pensioner [illegible]

Date Discharged	Time Discharged	Discharge Status
2/12/03	14:35	Home.

ICD10 [illegible]

Discharge planning should have a multidisciplinary approach.

Clinical management pathways improves the quality of care provided to patients

Educating patients regarding anticipated clinical interventions and expected outcomes and timeframes has been shown to improve outcomes and enhance patient satisfaction.

ADMISSION FRONT SHEET

MR 568

P111 Burnett ST

Date: 02.12.03
Time: 12:05:44

Discharge Medication List-GP & Pharmacy

Page: 1

Script Patient	Name	Script label	
234408		ASPIRIN 100mg	Take ONE tablet each MORNING
		ATORVASTATIN 20mg(Lipitor)	Take ONE tablet DAILY
		FRUSEMIDE 40mg (Lasix eq)	Take ONE tablet each MORNING
		THYROXINE 100mcg (Oroxine)	Take ONE tablet each MORNING

KEEP OUT OF THE REACH OF CHILDREN
BUNDABERG BASE HOSPITAL PH: 07-4152 1222

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.

BUNDABERG BASE HOSPITAL
No.
2/12/03

27 00

Bundaberg

HOSPITAL P111

SEX UR NO J0 73

GENERAL OBSERVATION SHEET

Ph (H)
Ph (B)

DATE	1/12/03	2	3	4	5	6		
TIME	AM PM	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 > <

260 250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 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		IMUT - NEG						
WEIGHT								
FOETAL HEART								
URINE PROTEIN	ALBUSTIK							
	BOIL							

GENERAL OBSERVATION SHEET

NKA HOSPITAL **Bundaberg Hospital** P111 **SEX** **UR NO**

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

0330 Chest Pain

DATE	TIME	T	P	R	BP	O_2	Sats.		Pain			REMARKS
												Central - radiating j
1/12/03	0446		90	18	145/85	RA	94%		0/10			5/10 in back.
	0452		ECG (1).				O_2 reapplied via Hudson @ 6L/min.					1/1 Anginine ↓ 0/ 1/1 Alpan
	0455		IV Cannula inserted & blds collected.									ABG. 7.3mmol/l
	0500		82.		125/94	6L	99%.		0/10.			
	0515	37.2	136	20.	116/71	6L	99%		0/10			Periods of Tachycard & Arrhyma
	0530		76-131	20.	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			

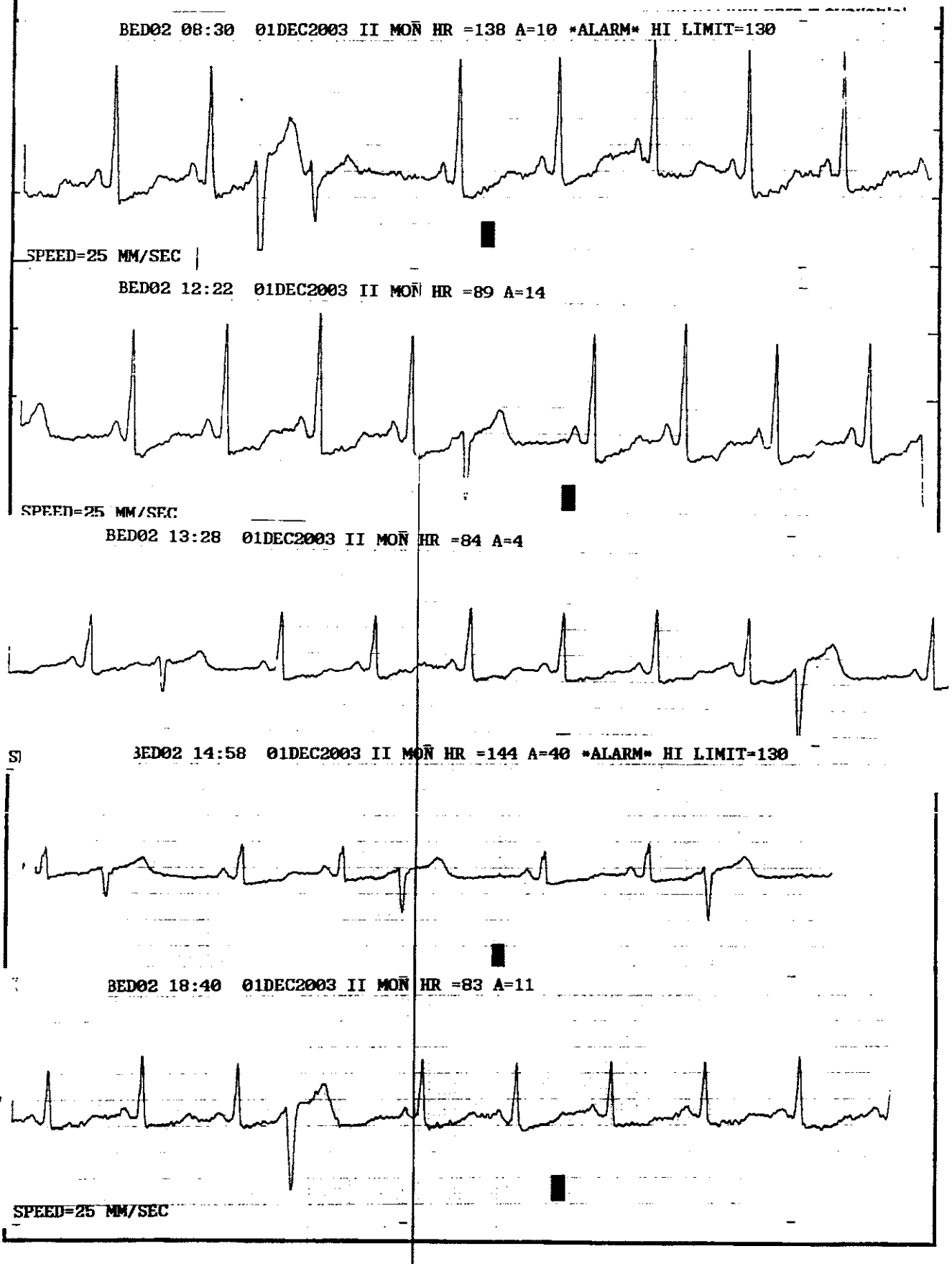
SPECIFIC OBSERVATION SHEET

BUNDABERG HEALTH SERVICE DISTRIC BUNDABERG HOSPITAL SEX UR NO 00 7

RADIOMETER PRINTOUTS

P111

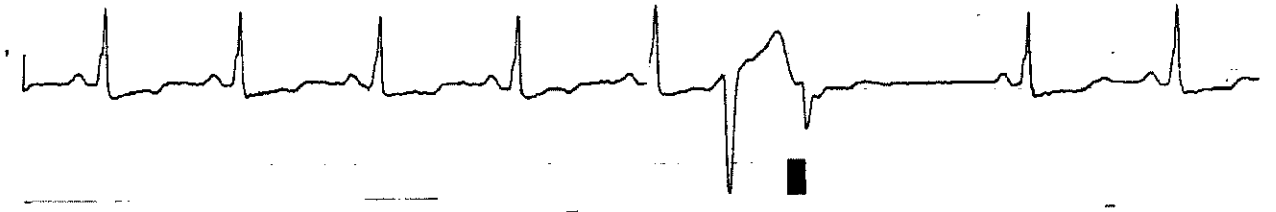
Ph(H)
Ph(B)



MR62G

P111 BED02 20:24 01DEC2003 II MON HR =80 A=6

00 76



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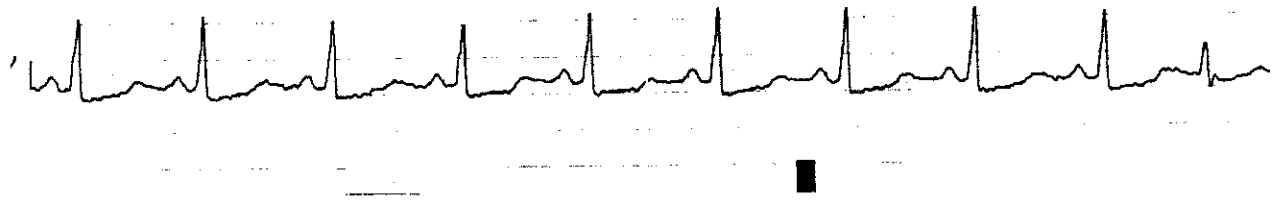

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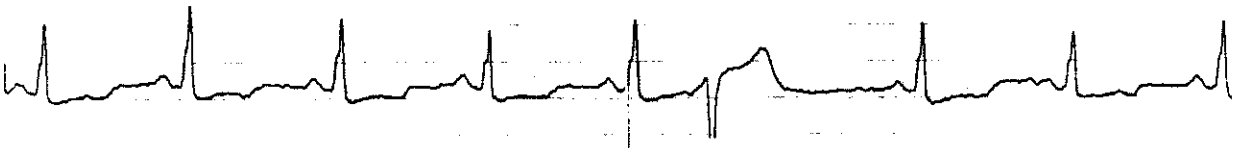

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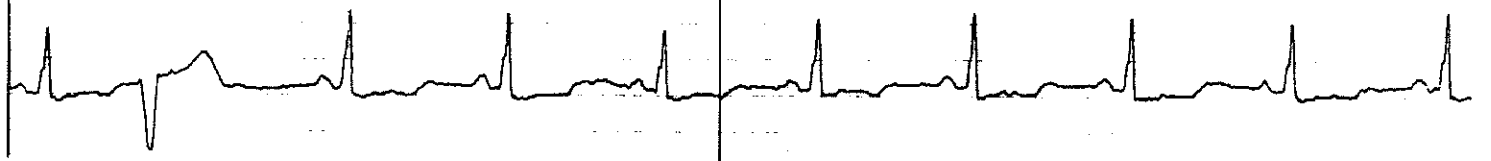

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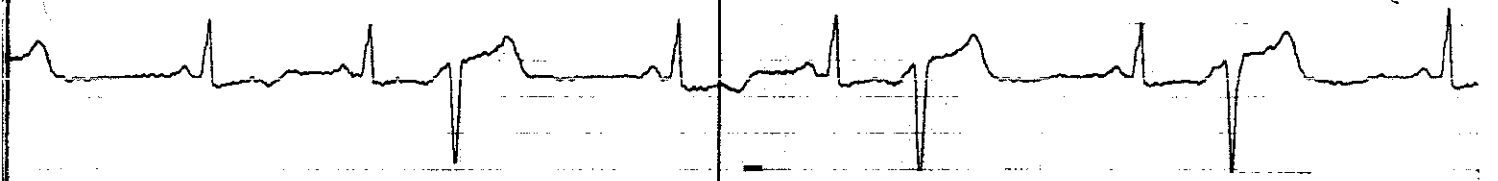

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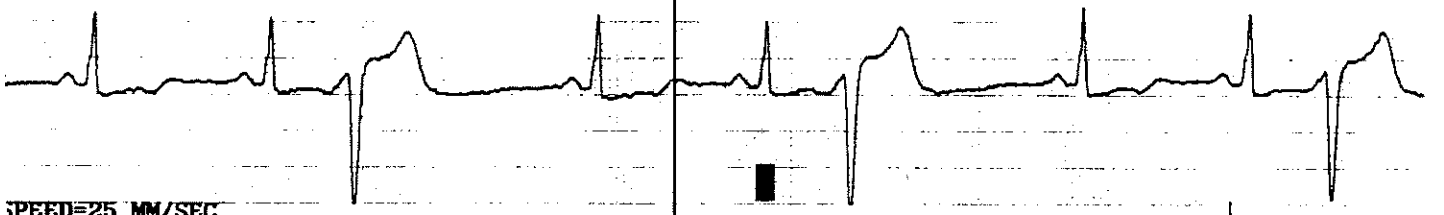


SPEED=25 MM/SEC

BUNDABERG HEALTH SERVICE DISTRICT

RADIOMETER PRINTOUTS

Surname: Pill 00 77

First Names:

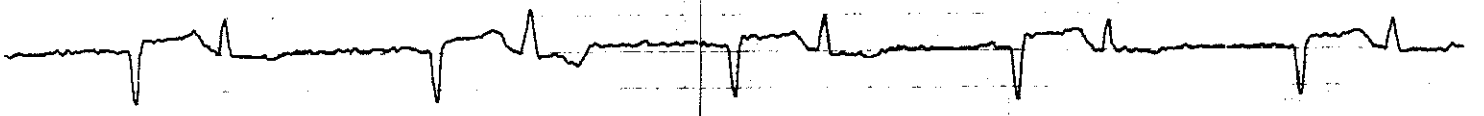
U.R. No:

Date of Birth:

(Please affix Patient ID label here if available)

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

END OF PAD



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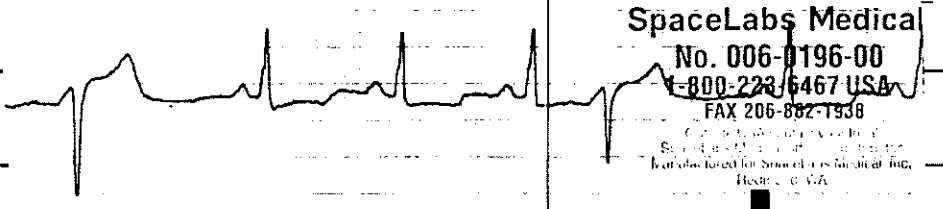
END OF PAD

PEED=25 MM



SpaceLabs Medical
No. 006-0196-00
1-800-22[illegible]6467 USA
FAX 206-882-1938

PEED=25 MM/SEC

MR62G

BUNDABERG HOSPITAL SEX UR NO

P111

Queensland Government
Queensland Health

BUNDABERG HEALTH SERVICE DISTRICT

PATIENT PROFILE

Ph(H)
Ph(B)

00 78

Date: 1.1.12.1.03 Time Admitted to Ward: 6pm 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 ☑ Notes:
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:

			Notified: (if applicable)
Meals on Wheels	Yes ☐ No ☑	Yes ☐ No ☐	
Home Help	Yes ☐ No ☑	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 ☐

Accomodation:

Lives in own home Yes ☐ No ☐
Lives in nursing home Yes ☐ No ☐
Lives in hostel Yes ☐ No ☐
Other:

Personal care status:

	Independent	Assist	Dependant
Hygiene/shower/bath	☑	☐	☐
Mobility/transfer	☑	☐	☐
Meals/feeding	☑	☐	☐
Dressing	☑	☐	☐
Toileting	☑	☐	☐

Someone to care for them Yes ☐ No ☐
Special needs:

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: MLx3.

General appearance:

Skin: General condition:

Pressure areas: Yes ☐ No ☐
Heels:
Sacrum:
Other:

MR69

00 79

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

Nutrition
How does patient describe their appetite: Poo ☐ Fair ☐ Good ☑ *Dietition 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:

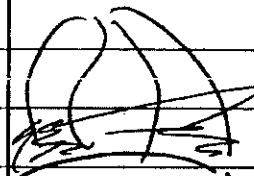
D Morris | S M MORRIS RN | 1/12/05.
Admitting nurse signature | Printed name/designation | Date

Bundaberg Base HOSPITAL | Bundaberg Hospital | 00 80 SEX UR NO

P111

INPATIENT PROGRESS NOTES

Ph (H)
Ph (B)

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
01/12/03	~~Hx~~ See on DEM Record.
0555	~~DX~~ CCF / unstable Angina ~~DDX~~? MI
SLSlobb	~~Summary~~
	(S) SOB on minimal exertion / weeks. Orthopnoea / slight dry cough / Recurrent central chest pain for 2/52 Chest pain relieved by GTN / Asp/ni MI history in '93/'95. Thyroid disease — on Thyroxine On regular GTN spray at home
	(O) Vitals Normal wt 68-2kg SaO2 94 (air) SaO2 99% (O2 at 6L/m) Bilateral chest crepts at base.
	(A) - CXR  Bilateral basal effusion
	- Troponin 0.52 (1)
	→ RBC / ~~UEC/LFT~~ T ⇒ Normal
	→ UEC / LFT ⇒ ~~Ready~~ ⇒ Normal
	(P) → Lasix 60mg IV Stat.
	→ MI Screen at Ward 10

INPATIENT PROGRESS NOTES

147714–GOPRINT ©

MR70

Bundaberg Base Hospital

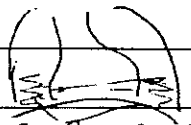
Bundaberg Hospital SEX UR NO

00 81

Pill

Ph (H)
Ph (B)

CONTINUATION SHEET

DATE AND TIME	HISTORY, EXAMINATION AND TREATMENT
01/12/03	FBC ⇒ Normal
0555	LFT ⇒ Normal ; CXR Basal opacity on base.
	UEC ⇒ Normal
	CK
	Troponin ⇒ 0.52 ↑  basal opacity
	D/W STRATTAN :
	→ for Admission and put on lasix. 6
	(P) → Admit
	→ Lasix 60mg IV stat
	→ RTP - up
	→ O2 at 6L/min
	→ for M.I screen in Ward.
	→ NO Telemetry available LS in ward 10 - To wait for medical team to Rev. at 0800hr.
	→ Thyroxin 100mcg PO daily
	→ GTN 300mcg PO PRN. LS
1/12/03 0725hrs	Nursing: Pt settled into bed. Placed on telemetry. Informed of RIB policy. WTU nad. PMH ——— Simmons RN (ENROL)
1/12/03 1044.	Heard Heart Visit states Pressure Pt "Heard attacks" not interested in further information at this time. Schuss RN (TOR144).

ACCIDENT & EM

DATE AND TIME	HISTORY, EXAMINATION AND TREATMENT
1/12	WR c Dr Graham
	Known CAD, prior MI
	S1+S2 heard JVP ⊖ chest sounds clear
	ECG old inf + antsep MI [illegible]
	Plan
	urgent CK
	if normal ⇒ stress test today 1130am
	Dr
	A/sid [illegible]
1/12	CK 120 122
	Plan
	Stress Sestamibi Today [illegible]
	12:15 next monday + wed. 8/12 + 10/12.
	Dr
	A/sid [illegible]
	If MI CK curve flat ⇒ DC to home
1/12/03 14:40	Resting in bed. Nil complaints of chest pain. CE2 and trop attended @ 12:00. Meds given as per MR85 — [illegible] Student (Evans)
	[illegible] RN (NICHOLSON)
1/12/03 2200	Nursing: Pt has been RIB this shift. No complaints of chest pain. Meds as per MR85 Cares as per care path — M Hanson RN (HANSON)

W 80-Govt. Printer, Qld.

Bundaberg HOSPITAL

BUNDABERG HOSPITAL SEX UR NO 00 83

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Ph (H)
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INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
2/12/03	0500hrs Rested quietly o/n. Telemetry cont'. Eganson o/n.
2/12/03	mobile & showering. Nil c/o noted.
1430hrs	Discharged home — Education RN (Nicholas)

INPATIENT PROGRESS NOTES

Bundaberg Dist. Health Service

CARE PATH ACTIONS (Formatted)

Care Path: MED-MI
Myocardial Infarction 00 84

Page: 1

Bundaberg Hospital SEX UR NO

Pill

Ph (H)
Ph (B)

INDICATOR	D.E.M. 1 / 12 / 02	Day 0 (First 24 Hrs) 1 / 12 / 02	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 Tridal Infusion if indicated Medications as Indicated:- ✓ Heparin / Anticoagulant ✓ Asprin Pain relief Antiemetic ✓ O2 ~~4 L/min~~ 6LPM	Medications as indicated:- Thrombolytic agent GTN if indicated Anticoagulant Morphine Atenolol Nitrates Sedation Antiemetic ~~Nil~~ as per MR&S	Medications as indicated:- Anticoagulant - Cease Heparin infusion at 48 hrs Asprin Morphine Atenolol Nitrates if indicated Sedation Aperient .
TREATMENTS	✓ IV access X 1 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)		Richardson	
RN (Evening)		M Hanson	
RN (Night)	LBray	K	
Allied Health			

Eg: ✓ RJD = Performed X RJD = Variance

Bundaberg HOSPITAL

BBH 7795081

	INTAKE												OUTPUT												
	ORAL N/G			PERIPH. I.V.			PERIPH. I.V.			C.V.L.			URINE		DRAINS						DRAINS				BOWELS
Time	TYPE	HRLY. VOL.	TOTAL	TYPE	HRLY. VOL.	TOTAL	TYPE	HRLY. VOL.	TOTAL	TYPE	HRLY. VOL.	TOTAL	HRLY. URINE	TOTAL		TOTAL		TOTAL		TOTAL		TOTAL		TOTAL	
0100																									
0200																									
0300																									
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2100																									
2200																									
2300																									
2400																									
TOTALS																									

INTAKE: ORAL N/G ..... I/V ..... C.V.L. ..... TOTAL ..... MEASURED BALANCE ..... ± WEIGHT 00

OUTPUT: URINE ..... N/G ..... I.C.C. ..... DRAINS ..... Pill ..... TOTAL ..... TRUE BALANCE 85

MR81 DATE WARD N/ Must Sign: U.R. No.

Bundaberg Health Service District

REGULAR MEDICATION CHART

BUNDABERG HOSPITAL SEX UR NO

00 87

Pitt

Ph (H)
Ph (B)

Record of Administration 2002

Date → / Time ↓ — 1/12 | 2 | 3 | 4 | 5

Drug: Frusemide
Route: IV | Dose: 60mg | Freq: daily | Start: 1/12
Doctor: Siolo | Time check: 0900 DB
Discharge Supply: ☐ days | Dr's Signature | Pharmacist

Drug: Thyroxine
Route: PO | Dose: 100mcg | Freq: daily | Start: 1/12
Doctor: Siolo | Time check: 0730 DB
Discharge Supply: 5 days | Dr's Signature | Pharmacist

Drug: Aspirin
Route: PO | Dose: 100mg | Freq: OD | Start: 1/12
Doctor: R | Time check:
Discharge Supply: 5 days | Dr's Signature | Pharmacist

Drug: lasix.
Route: PO | Dose: 40mg | Freq: OD | Start: 1/12
Doctor: R | Time check:
Discharge Supply: 5 days | Dr's Signature | Pharmacist

Drug: lipitor
Route: PO | Dose: 20mg | Freq: OD | Start: 1/12
Doctor: L | Time check:
Discharge Supply: 5 days | Dr's Signature | Pharmacist

Drug:
Route: | Dose: | Freq: | Start:
Doctor: | Time check:
Discharge Supply: ☐ days | Dr's Signature | Pharmacist

BUNDABERG BASE HOSPITAL
DATE 1/12/03 No. 244408

Bundaberg Health Service District

PRN MEDICATION CHART

00 88

Bundaberg Hospital

P111

SEX UR NO

Ph (H)

Ph (B)

PRN ADMINISTRATION

DRUG GTN			
ROUTE	DOSE	FREQ.	START
sublingual	300mcg	PRN	1/12
DOCTOR Susielo		Time check	

Date	Time	Dose	Sig	Date	Time	Dose	Sig	Date	Time	Dose	Sig

Discharge Supply ☐ days Dr's Signature

Pharmacist

PRN ADMINISTRATION

DRUG			
ROUTE	DOSE	FREQ.	START
DOCTOR		Time check	

Date	Time	Dose	Sig	Date	Time	Dose	Sig	Date	Time	Dose	Sig

Discharge Supply ☐ days Dr's Signature

Pharmacist

PRN ADMINISTRATION

DRUG			
ROUTE	DOSE	FREQ.	START
DOCTOR		Time check	

Date	Time	Dose	Sig	Date	Time	Dose	Sig	Date	Time	Dose	Sig

Discharge Supply ☐ days Dr's Signature

Pharmacist

PRN ADMINISTRATION

DRUG			
ROUTE	DOSE	FREQ.	START
DOCTOR		Time check	

Date	Time	Dose	Sig	Date	Time	Dose	Sig	Date	Time	Dose	Sig

Discharge Supply ☐ days Dr's Signature

Pharmacist

DRUGS WITH VARIABLE DOSE

DRUG	ROUTE	Discharge supply .... days. Dr's signature:

DATE	TIME	DOSE	DOCTOR	NURSE

DRUG	ROUTE	Discharge supply .... days. Dr's signature:

DATE	TIME	DOSE	DOCTOR	NURSE

BUNDABERG BASE HOSPITAL

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

P111

Ph(H)
Ph(B)

ADMISSION RECORDS

ADMISSION DATE

12/06/95

WIDE BAY REGION
Bundaberg HOSPITAL
DISCHARGE SUMMARY

Local Doctor Joines DR HARTLEY
Address Hinkler Place
MARYBOROUGH ST
BUNDABERG

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

Ph (H)
Ph (B)

00 89

Admission Date: 12/6/95

Discharge to: ..... Clinic: ..... Appt. date: ..... time: .....

Symptoms/signs on presentation 1 HR central chest pain.
Silent anteroseptal + inf. MI in past
PHx Hypothyroidism.

ADMITTING DIAGNOSIS ?MI

*** PRINCIPAL DIAGNOSIS**
Atypical Chest Pain.

Secondary Diagnoses .....

PRINCIPLE PROCEDURE .....

Secondary procedure/s .....

INVESTIGATIONS:

	Y	N	NAD	WRITE ABNORMAL RESULTS
F.B.C.	☐	☐	☐	Serial CKs (N)
BIOCHEM	☐	☐	☐	ECG – no new changes
L.F.T.'s	☐	☐	☐	
MICRO	☐	☐	☐	
HISTOLOGY	☐	☐	☐	FBC (N) MBA (N)
X-RAY	☐	☐	☐	
CT SCAN	☐	☐	☐	
E.C.G.	☐	☐	☐	Awaiting TFT/Lipids — copy to LMO
OTHER	☐	☐	☐	

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 .....
Aspirin 150mg daily
Angmine 1 s/l prn

R.M.O. Swannell (sign) C SWANNELL (print) DATE 14.6.95

CONSULTANT ..... (sign) STRAHAN (print) DATE .....

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

DISCHARGE SUMMARY

BUNDABERG BASE HOSPITAL

UR 00 90

PUBLIC

Title | Surname | Given Names | Date of Birth | Age

Phil

Address | Sex | M.S. | Country of Birth | Religion

Ethnic Origin

Telephone - Home | Telephone - Business | Occupation (Current or Last)

First Contact | Alternative Contact

If discharged in last 7 days, from which hospital | Date Admitted | Time Admitted | Admission Source

12 JUN 1995 | 12:40 | A & E

Referring Doctor/Person | Unit | Ward | Bed | Treating Doctor

MED | 10 | STRAHAN

Account Class | Health Fund | Health Schedule

GPE

Medicare Number | Pension Number

Date Discharged | Time Discharged | Discharge Status

14.6.95 | 1310hrs | Home

ICD9CM CODES

P	78659		
	412		
	2720		
	2449		
	4149		

ADMISSION FRONT SHEET

MR 56B

Burnie berg HOSPITAL

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

00 91

P111

Ph(H)

Ph(B)

GENERAL OBSERVATION SHEET

DATE June '95 | 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

36.2

41.5 41 40.5 40 39.5 39 38.5 38 37.5 37 36.5 36 35.5

41.5° 41° 40.5° 40° 39.5° 39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5°

PULSE ° BLOOD PRESSURE

65 112/70

260 250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40

RESPIRATIONS

20

120 115 110 105 100 95 90 85 80 75 70 65 60 55 50 45 40 35 30 25 20 15

BOWELS		✓	✓					
WEIGHT		71.2kg.						
FOETAL HEART		NAD						
URINE PROTEIN	ALBUSTIK	NAD.						
	BOIL							

GENERAL OBSERVATION SHEET

PATIENT PROFILE

DATE: 12-6-95

TIME: 1300

WARD: 10

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

P111

Ph(H)
Ph(B)

KNOWN ALLERGIES (Record in red) Nil Known

00 92

PATIENT MEDICATIONS: YES/(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)

Do you have glasses? (Yes)/No *Retained by patient* Yes/No Did not
Entered into 'Clothes Book' Yes/(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 responsibilites?
(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)
If yes, state which service/s.

Ambulance Subscriber Yes/(No)

L Haviland RN

NURSES SIGNATURE & DESIGNATION

To be used for patients in hospital > 48 hours.

Revised October, 1993.

NR 69 A

STK NO. 7799069

PATIENT PROFILE

MR69A

Bundaberg HOSPITAL

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

P111

Ph(H)
Ph(B)

00 93

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
12/6/95	
Macmap	
PHO	
12.20	J
PC	chest Pain
HPC	H/O MI x 2
	Last one 2 years ago
	No H/O Angina since
	Today sudden onset of central
	Chestpain whilst at rest; also between
	Burning shoulder blades
	radiating across chest
	felt SOB
	Navanaea &/v
	Vomited x 1
	Not clammy
	Pain worse than that of MI but of
	Similar nature
	Not pleuritic
	No cough No haemaphysis
	RF
	Male Angina
	Nan Smoke
	Previous MI x2
	NOT BP
	Not Diabetic
	not ↑.

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
PMH	as ever ROS Nil to Add
DH	None usually well
Smokes	None
Alcohol	None
Allergies	NKA
SH	Lives c husband
OE	Well but anxious
	Not cachexic
	Pulse 57
	BP 122/65
	JVP →
	HS I + II
	RR 18/min Nad under bedspringing
	Chest few crepts
	and Soft
	Nontender
	No masses
	BS ✓
	CNS anxious but grossly (N)
	Imp ? oesophageal spasm / Reflux.
	To rule out cardiac cause
	FOR C. Enzymes, ECG
	MRSA ✓
	FBC –
	CXR ✓
	Serial ECG. ECG? old ant MI

Bundaberg HOSPITAL

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

00 95

P111

(2)

Ph(H)
Ph(B)

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
12/6/95	
	Routine obs
	notify concerns if he develops
	any further chest pain. [signature]
12-6-95	Nursing 1800hrs. Admission via A+E
	as above. Settled into ward. Observations
	satisfactory. For CE no 2 this pm.
	No complaints of chest pain since
	~~arr~~ arrival to ward. — S Harland (RN)
12/6/95	INTERN.
	PC Chest pain – dull, 'tight', severe (7/10)
	feeling in centre
	of chest (retro-
	sternal)
	– pain radiated through to
	back at times. No radiation
	to neck/jaw/arms
	– pain lasted ~½ hr to 1 hour
	gradually receded (didn't
	take anything for it)
	– felt nauseous, cold +
	clammy, vomited x1
	Nausea passed as pain did
	No dizziness/pre-syncope
	– no acid reflux into
	mouth/throat. (Never
	suffered with heartburn/reflux)

INPATIENT PROGRESS NOTES

147714—GOPRINT © MR70

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT

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

Hx of IHD - MI's x 2
last MI ~ 8 yrs ago
2nd MI ~ 2 yrs ago
* reports no chest pain before/between/since MI's 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
- MI's x 2 - ~8 yr 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/K * alcohol - none
* tobacco - none * medications - none.

Bundaberg HOSPITAL --ID---------SEX---UR NO--

00 97 P111

Ph (H)
Ph (B)

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
	O/E Aplobrile, in no distress
	CVS HR = 60 BP = 110/70 JVP NE
	HS x 2 no murmurs
	Resp chest expansion fair
	breath sounds vesicular R=L
	no crackles / wheezes
	Abdo soft, obese, non-tender
	no masses / organomegaly
	palpable
	CNS grossly intact.
	ECG – no new Δ's, no ST depression
	Impression: ? severe angina / MI
	? other
	Plan: · admit
	· serial CE's / ECG, bloods (as done in A+E), CXR FBE MBA
	· TFT's mane
	· (N) diet
	· routine obs
	· notify if further chest pain / if concerns
	· ~~start~~ Aspirin 150mg daily (hold thyroxine until TFT's) ~~if patient~~
12.6.95	Pt well. No chest pain. Wounds patent.
2245	Obs satisfactory. Cx sed collected. Bloods
13-6-95	0400 hrs. Observed to have rested well.
nocte	Frequently checked. Wounds patent. S McKenlay

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
13/6/95	DR STRAHAN'S WR
	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's	O/E HR 84 BP 110/70 JVPNE HS (N)
	chest clear
	Plan – await CE's
	– thyroid Ab
	– fasting lipids tomorrow a.m.
	– ETT as outpatient
	following D/C.
	J. Robertson
	(INTERN)
13.6.95	Pt well, no chest pain, no shortness of breath.
1455	[illegible] patent [illegible], site (nodules).
	[illegible] ([illegible]). Pt to fast 12 MN/
	H2O only for fasting lipids in am. [illegible]
13-6-95	Nursing 2120hrs: Self-caring. IVC patent.
	No complaints of chestpain. For NBM
	from midnight. — SHolland RN
14-6 95	0400 Observed to have rested
nocte	well, frequently checked. IV [illegible] patent
	N.B.M from 2400 hrs (H2O only) for fasting
	Lipids. S McKinlay CN

Bundaberg HOSPITAL

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

00 99

P111

Ph (H)
Ph (B)

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
14/6/95	JHO/SWANNELL
	UMO - Dr ~~Jones~~ (Hinkler Place) → no longer the G.P.
	— Dr Hartley Maryborough St.
	J. Roberts

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		✓

Kgarson

SIGNATURE OF REGISTERED NURSE

14.6.95

DATE

(Stk No. 7799079)

14.6.95	No c/o chest pain D/C charged home
1730hrs	Kgarson RN

INPATIENT PROGRESS NOTES

B'Bera HOSPITAL

INPATIENT MEDICATION CHART

Admission

From 12/6/95 To ..../...../.....

Admission Weight.....**Kg**

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

Pill

Ph(H) :
Ph(B)

00100

AVOID ERRORS: Drugs will not be administered without a written, legible, complete prescription.

ADVERSE DRUG REACTIONS	DRUG	MONTH/YEAR	NATURE OF REACTION
	N/K.		

ONCE ONLY (AND PREMEDICATION) DRUGS

DATE	TIME	DRUG	DOSE	ROUTE	DOCTOR	GIVEN BY	TIME GIVEN

DRUGS WITH VARIABLE DOSE

DRUG			ROUTE	
DATE	TIME	DOSE	DOCTOR	NURSE

DRUG			ROUTE	
DATE	TIME	DOSE	DOCTOR	NURSE

INPATIENT MEDICATION CHART

REGULAR PRESCRIPTIONS	SURNAME Pill	GIVEN NAMES
DRUG REACTIONS: NIK (See front of Sheet)	ADMINISTRATION TIMES (According to Hospital Policy) 1995	FOR DRUGS NOT GIVEN INSERT (According to Hospital Policy) R REFUSED A ABSENT S STARVING N NO STOCK

001012

RECORD OF ADMINISTRATION	Date → / Time ↓	12/6	13/6	14/6	15/6
DRUG: ASPIRIN	0730	X	MK		
ROUTE: oral / DOSE: 150 mg / FREQ.: daily / START: 12/6/95					
DOCTOR: J Robertson	Pharmacist: DJC 10x3007				
DRUG: Normal Saline	0600	X	[illegible]	[illegible]	
ROUTE: IV / DOSE: 5mls / FREQ.: TDS / START: 12/6/95	1400	X	?		
DOCTOR	Pharmacist	2100	MK		
DRUG					
ROUTE / DOSE / FREQ. / START					
DOCTOR	Pharmacist				
DRUG					
ROUTE / DOSE / FREQ. / START					
DOCTOR	Pharmacist				
DRUG					
ROUTE / DOSE / FREQ. / START					
DOCTOR	Pharmacist				
DRUG					
ROUTE / DOSE / FREQ. / START					
DOCTOR	Pharmacist				
DRUG					
ROUTE / DOSE / FREQ. / START					
DOCTOR	Pharmacist				

SURNAME	GIVEN NAMES

00102A

PRN ADMINISTRATION

DRUG	Date	Time	Sig.	Date	Time	Sig.	Date	Time	Sig.	Date	Time	Sig.
Mylanta												
ROUTE: O / DOSE: 10mls / FREQ.: 8°PRN / START: 12/6												
DOCTOR: [signature] / Pharmacist												
DRUG: Panadol												
ROUTE: O / DOSE: 1g / FREQ.: 6° / START: 12/6												
DOCTOR: [signature] / Pharmacist												
DRUG												
ROUTE / DOSE / FREQ. / START												
DOCTOR / Pharmacist												
DRUG												
ROUTE / DOSE / FREQ. / START												
DOCTOR / Pharmacist												

INPATIENT DISCHARGE PRESCRIPTION

U.R. No.: D.O.B.
Wt.:

Patient's Name:

Address:

Doctor's Name: *(Please Print)*

Date

Cas.:

Ward/Clinic:

	Days Reqd	Pharmacy

M.O. SIGNATURE:

BUNDABERG BASE HOSPITAL

NURSING CARE RECORD

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

P111

Ph (H)
Ph (B)

00102B.

MEDICAL DIAGNOSIS Chest pain

DATE	SURGICAL / MEDICAL PROCEDURES
12/6.	IVC (A+E.

DATE	SPECIAL INSTRUCTIONS
12/6	H/24 TPR BP
	Admission weight
	Admission WTU.
14/6	TPR & BP - BD 1600 1800

DATE	PATHOLOGY / X-RAY REQUESTS
12/6	CE ~~No 1~~, FBC, MBA (A+E).
	CE NO. 2
13/6	CE NO. 3 TFT 0800
14/6	Thyroid Antibodies
14/6	Fasting Lipids.

DATE	SPECIAL NEEDS
	PHYSIO
	SOCIAL WORKER
	OCCUP. THERAPY
	OTHERS

DATE	DIET
12/6.	Healthy Heart
13/6	N.B.M. 2400 (water to drink)

MR 92

BBH 7799092

BUNDABERG BASE HOSPITAL

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

P111

Ph(H)
Ph(B)

ADMISSION RECORDS

ADMISSION DATE
18/06/93

PLEASE ENSURE HOSPITAL NAME APPEARS ON ALL COPIES

Bundaberg HOSPITAL

00103

PIII

SUMMARY ON DISCHARGE

(Affix Patient Identification Label Here)

A more detailed summary will be forwarded.

TO: Copy sent to Junior

☐ DOCTOR

No. & STREET

SUBURB POSTCODE

COPIES SENT TO:—

(1)

(2)

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

DATE OF ADMISSION: 18/06/93 CONSULTANT: PINN

DATE OF DISCHARGE: 28/06/93 WARD: 10

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 – TNI inf leads.

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

CKMB 26

TREATMENT/OPERATION patch commenced – removed due to hypotension 21/38, Continue thyroxine

COMPLICATIONS/CLINICAL COURSE as TFT's revealed hypothyroidism

Start Atenolol + Aspirin + Imdur

* Repeat TFT's in 4/52.

MEDICATION ON DISCHARGE Angimine S/L ↑ prn

Aspirin ō 150 mg daily

Atenolol ō 50 mg mane

Imdur ō 60 mg mane

Thyroxine ō 100µg daily

Miconazole top 1 squirt bd 1/52

DISCHARGE/FOLLOW-UP

☐ Care of referring doctor ☐ Other Hospital

☐ O.P.D. Clinic ☐ Nursing Home

☐ Other

CLINIC PINN OPD 6/52

APPT. DATE / / TIME am pm

Signature M Taylor TAYLOR

Status HMO Date 28/6/93

118928—H 860—GOPRINT 1/91 MR53

SUMMARY ON DISCHARGE

HOSPITAL Bundaberg

00104

1 print firmly with ball point pen
2 for supplied answers, place code in appropriate box
3 if label is missing or incorrect complete PATIENT DETAILS
4 for a chargeable patient complete ACCOUNT DETAILS p3

PATIENT DETAILS

U.R. No. P111

SURNAME

FIRST NAME

SECOND INITIAL

USUAL ADDRESS — No. & Street

Suburb/Town

A.S.G.C.

POSTCODE

OCCUPATION

SEX (M or F)

CONTACT NAME

CONTACT PHONE

RELATIONSHIP

MEDICARE No.

AGE

D.O.B.

RELIGION

ADMISSION DETAILS

DATE ADMITTED 18 06 93

TIME ADMITTED (24 hr clock) 1840

REGISTER? (G or M) G

BOARDER? (Y or N)

MARITAL STATUS (1 single, 2 married/de facto, 3 widowed, 4 divorced, 5 separated) 2

PERMANENT AUSTRALIAN RESIDENT? (Y or N)

MEDICARE ELIGIBILITY (1 eligible, 2 not eligible, 3 not identifiable) 1

COUNTRY OF BIRTH

ETHNIC ORIGIN (1 caucasian-european, 2 aboriginal, 3 Torres St. Is., 4 asian, 5 other) 1

INPATIENT TYPE (1 acute, 2 nursing home type) 1

COMPENSABLE STATUS (1 workers (Q'ld), 2 workers (other), 3 third party, 4 not compensable) 4

SOURCE OF ADMISSION (1 priv. med prac., 2 casualty, 3 outpatient, 4 other hospital, 5 nursing home transfer, 6 status transfer, 7 other) 2

PATIENT ACCOMMODATION (1 standard, 2 private shared, 3 private single) 1

HOSPITAL INSURANCE (1 insured, 2 not insured) 2

ADMITTING WARD 1 CCU

Have you been discharged from any hospital in the last 7 days? (Y or N) N

If YES, which hospital?

total length of stay? (in days) without breaks of more than 7 days in previous hospitals

PATIENT MOVEMENTS

WARD TRANSFERS—state ward transferred to and the date

TO DATE

TO DATE

STATUS TRANSFERS—INPATIENT TYPE 1 acute 2 L.S.N.M.T.

NEW STATUS DATE

NEW STATUS DATE

STATUS TRANSFERS—PATIENT ACCOMMODATION 1 standard 2 private shared 3 private single

NEW STATUS DATE

NEW STATUS DATE

OUT—ON—LEAVE

FROM TO

FROM TO

DISCHARGE DETAILS

DATE DISCHARGED 28 06 93

TIME DISCHARGED (24 hr clock) 1235

DISCHARGE STATUS (1 home, 2 other hospital, 3 nursing home, 4 other institution, 5 died, 6 status transfer, 7 discharged at own risk, 8 other) 1

DIAGNOSIS ON DISCHARGE

PRINCIPAL CONDITION TREATED (PLEASE PRINT)

(1) Inferior MI 410.41

2449.

OTHER CONDITIONS TREATED (PLEASE PRINT)

(2) Hypothyroid

OPERATION AND/OR PROCEDURE (PLEASE PRINT)

If no operation(s)/procedure(s) please tick box ✓

Principal

Others

EXTERNAL CAUSE OF INJURY/POISONING (PLEASE PRINT)

How it Happened

Place of Occurrence (e.g. home, street, work)

TREATING DOCTOR Name PINN

Signature

HOSPITAL USE ONLY

L.M.O. DR.

ADDRESS

LETTER TO DOCTOR/OTHER AGENCY

INFECTIOUS DISEASE NOTIFIED

SUMMARY DICTATED DATE ___/___/___

H702—Govt. Printer, Qld.

Bundaberg HOSPITAL

00103

Pill

GENERAL OBSERVATION SHEET

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

PULSE ° BLOOD PRESSURE X

RESPIRATIONS

GENERAL OBSERVATION SHEET

BOWELS							
WEIGHT							
FOETAL HEART							
URINE PROTEIN	ALBUSTIK						
	BOIL						

W 62—Govt. Printer, Qld.

21-6-93

MR60

HOSPITAL

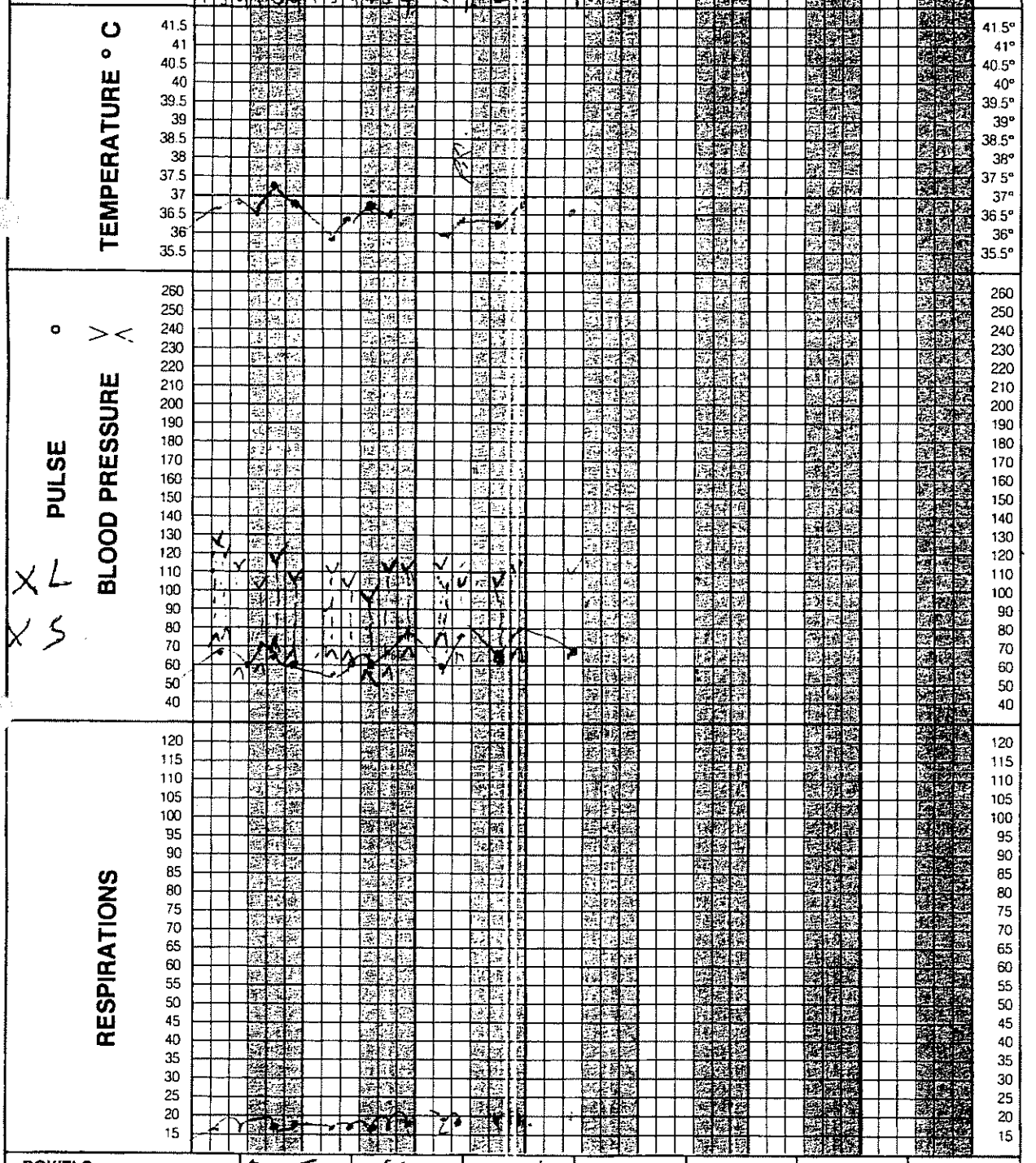
00106

P111

GENERAL OBSERVATION SHEET

(Affix Patient Identification Label Here)

DATE	25/6/93	26/6	27/6	28/6				
TIME	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM



BOWELS		T	T					
WEIGHT		67.7kg	67.7kg					
FOETAL HEART			67.75kg					
URINE PROTEIN	ALBUSTIK							
	BOIL							

W 62—Govt. Printer, Qld.

Bundaberg HOSPITAL R?

00107

DAILY FLUID SUMMARY

Pill

DATE	INTAKE			OUTPUT					MEASURED BALANCE
	ORAL	INFUSED	TOTAL	URINE	GASTRIC	DRAINS	BOWELS	TOTAL	
18/6	150	—	150	500	—	—	—	500	Accept.
19/6	750	—	750	570	—	—	—	570	> 180

DAILY FLUID SUMMARY

W 76—Govt. Printer, Qld.

MB61

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00108

P111

SPECIFIC OBSERVATION SHEET

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	FiO2	SaO2	REMARKS
18/6/93	1850.		55	14.	125/61	3l.		New ⓟ admitted to ICU. c/o chest pain 8/10 in severity between shoulder blades. ECG recorded
	1855				119/64			½ Anginine given. pain now 1/10
	1900		63	12	96/51	3l.		pain 1/10 persisting
	1905		62	14	109/57	3l		½ Anginine repeated. transiderm 2S applied. pain shift 1/10 in severity
	1915				108/56			
	1930		60	18	117/68	3l.		Pain 1/10 but getting better. Pain remains between shoulder blades
	1945		60	18	117/62	3l		Pain now dull ache - no distress.
	2000		62	20.	122/63	3l		IV Morphia 2.5mg + IV Maxolon 10 mg given
	2005		61	20	113/53	3l.		No pain now.
	2020		60	20.	104/48	3l.		NO C/O pain. Monitor SR
	2045		68.	20	107/56	3l.		NO C/O pain. Monitor SR.
	2200		55	18	95/52	3l		Asleep Monitor SR
	2300		57	14	95/43	3l		Asleep monitor SR
19/6/93	2400		59	10	91/49	3l		2nd CE's taken. Resting, mild pain Monitor SR
	0100		53	17	94/53	3l		Sleeping.
	0220		73	12	96/52	3l		Mil pain, resting Monitor SR
	0300		59	12	77/36	3l		SB sleeping GTN patch removed
	0305.				84/38			
	0315				81/38			SB no c/o pain.
	0325				85/42			

SPECIFIC OBSERVATION SHEET

W 64—Govt Printer, Qld.

INDICATE OBSERVATIONS IN SEPARATE COLUMNS

00109

DATE	TIME	T	P	R	BP	O_2	S_aO_2	REMARKS
19/6/93	0400		52	15	85/42	3L/m		Sleeping
	0500		56	14	94/53	3L/m		Sleeping
	0600	36.5	56	14	ok 108/64			no pain 64kg.
					↑ 117/60			
	1030	36.7	55	16	110/61	off		Reading quietly. Pain free
	1200		70	18		—		Pain free. diet ↑
	1800		84	24	117/73	—		
	2045	37.3	74	18	121/59			Pain free
	2255		82	18				Man - SR 96 %
								Resting quietly
20/6/93	0210		72	29				Man - SR 96 %
								Resting quietly
	0400		66	33				Man - SR Lying ®
								eyes closed
	0555	37.3	91	20	116/55	off		Man - SR 96 %
					105/69	↑		Afebrile Wt 67kg
								Undressed in bed
	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/R.
	~~2300~~		~~126~~	~~28~~	~~129/52~~			~~Sleeping comfortably~~
								~~NESB for sleeping~~ with intervention
	2400		62	16				Monitor SR sleeping.
21/6/93	0200		56	18				Monitor SR Sleeping
	0600	36.1	66	18	® 105/63			MONITOR - SR. No SOB
					⑤ 111/63			
	1100	36.8	66	17	105/52			Showered. Monitor SR. Pain free.
	1600		72	18				Mobilising to toilet. Monitor S/R

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00110

DATE 18/6/93

TIME 1840

WARD ICU

PATIENT PROFILE

(Nursing History and Assessment Sheet)

SURNAME: P111 GIVEN NAMES: AGE:

CONSULTANT DR DONNELLY M.O. DR. TAYLOR P/D MJ

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: ?o 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

Bundaberg HOSPITAL

00111

Pill

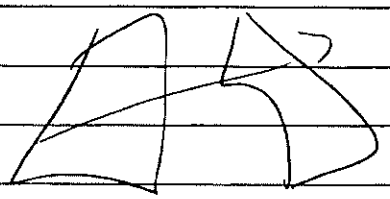
INPATIENT PROGRESS NOTES

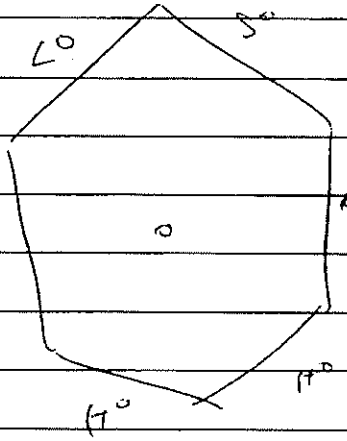
(Affix Patient Identification Label Here)

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
18-6-93	59 y old ♀ pres c 1/7 vague chest pain. Began this a.m. Has generally not changed - better at times. Goes into back. No other radn.
	No associated SOB / weakness / ↓LOC.
	No anoc" c food.
	Not ↑ c exertion or ↓ c rest.
	Has "just not feeling well".
	Nausea. 1x episode vomiting - water.
	No Hx URTI / cough.
	Central chest pain vague in nature.
	PMHx: ♦MI 5y ago - no chest pain! CVA° DM° angina°. epilepsy° asthma°. ♦Hypothyroidism - stopped thyroxine self.
	PSHx: nil
	Allgies: NIK.
	Medicat": nil.
	O/E: Looks well. A little confused. Well-oriented.
	PR 80. BP:
	JVPNE
	Carotids x 2
	AB → x
	HS x 2 1 — II

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT	00112

Chest  NAD.
AE good
wheeze° crackles°

Abdo 

ECG - no ST Δ.
Q wave infarct ant + inf. ? age.

CE: ↑ CK.

For FBE ✓
TFT ✓
IV line
admit for obs.

18.06.93 2230hrs: Arrived in ICU @ 1850hrs: P-55 R-14 BP 126/61 O_2 - 3lpm. Cpts of chest pain of 6/10 between shoulder blades. ECG taken. Angune given - ½ ↓ pain decreased to 4/10. then to a dull ache. IV morphine & maxalon given pain ceased. Tolerated light diet & fluids. Asleep @ TOR. Voided ✓ - U/T tr Protein & Ketones. IVB insitu & patent.

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00113

P111

INPATIENT PROGRESS NOTES

(Affix Patient Identification Label Here)

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
2330	Pain settled
	A. [illegible]
	ECG - [illegible]
	MOA / [illegible] / CS: ② / ⑬ ? [illegible]
	[illegible]
	[signature]
19/8/93 0320	ATSP re ↓ BP
	25 mg nitro patch placed on at ~2200
	BP in A+E 125/61
	↓ gradually to 78/36
	patch removed at 0300
	BP now 87/38
	I: hypotensive response to transdermal patch
	P: leave off patch
	[signature] B. Ritchie

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
19-6-93 0645	CVS:- Monitor SB Rate. SZ – 73. BP 78/36–117/60
	Noc/o pain. BP ↓ at 0300hrs 25mg GTN patch
	removed.
	Resp:- No SOB.
	GUS:- Passed 500mls urine.
	IV cannula patent ✓
	Fasting lipids done — Brian Rn.
19/6/93	Very mild ache between shoulder blades.
	No central chest pain
	Unable to tolerate GTN due to hypotension
	No failure. 2 heart sounds no bruits.
	CK yesterday ↑.
	Tx/ Continue monitor today in ICU
	Oxygen ± Morph if pain relief
	C.T. with aspirin
	Permit today's exercise
	Dr.
19/6/93 1330hrs	Neuro – resting quietly. Uncomplaining
	CVS – Monitor SR set BP 110/61 @ 1000hrs
	HR 55-75 Colour pink. Skin warm & dry
	Resp – RR SOB/dyspnoea. RR 18-20. CXR attended
	GIT – tolerating diet. Nil nausea.
	GUS – HPU x 2 – 150mls in total.
	IV – Jelco (R) hand.
	Psycho/social – visited by husband & son
	Brian
19/6/93 1630	All CE's raised.
	Peak CK 752.
	Pain free all day
	to stay on ICU
	Heather.

Bundaberg HOSPITAL

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INPATIENT PROGRESS NOTES

(Affix Patient Identification Label Here)

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
19/6/93	CVS (P) relaxed and watching TV. Psychosocial (P) visited
2015	by her husband + son. CVS monitor ic Sinus Rhythm T° 37.3
	IV Jelco patent No chest pain RR SpO2 95% on air
	GIT Appetite fair Oral fluids encouraged GUS. Output only
	270 mls. Nico @ ROR. C. Bygrave (RRN)
20-6-93	Neuro :- No Gp overnight. (P) T° 37.3 at 0600.
0625	- Wt 67kgs.
RN	CVS :- 66 - 91 BP 116/75 Lying 105/69 Stand.
	- Monitor in SR
	Resp - Nil Distress
	GUS - Voided 200 mls x 1. N.P.O.
	IV - Cannula flushed + Patent
20/6/93	Pain - free.
	ECG - T-wave inversion all inf. leads.
	BP 80
	JVP ↔
	HS 1 -11 -1
	Chest - few basal crops.
	→ MI protocol.
	Start Atenolol 25 mg.
	Await IFTs.

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
20.6.93 1430Hs	ECG attended. Afebrile P70-80. Meds given as charted. IV Cannula flushed & patent. Day 2 Cardiac Protocol. Awaiting TFTs - [signature] RN
	Addit. Nil complaints of pain/tightness — [signature] RN (YEOMAN)
20.6.93 2100.	CNS: Pain free evening. Sponged self c̄ no ill effects.
	CVS: 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
	CVS:- 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
	[signature] RN
21.6.93	Donnelly WR
	Well
	Obs Stable BP 110/70
	Pain few hours duration
	CK peak 752 CKMB 24
	LD 24 270
	Chest Clear. R 60
	For LDH today.
	To ward 10.
	Prob of infect.
	Swab under breast. - Start miconazole - ? Δ Nystatin with swab results.
	[signature]

00116

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INPATIENT PROGRESS NOTES

(Affix Patient Identification Label Here)

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
21/6/93.	NEURO: Showered self - no c/o SOB or
1410 HRS	chest pain.
	CVS: Monitor SR HR 54-62. BP 105/52.
	Afebrile.
	RESP: No SOB.
	GIT: Tolerating Healthy Heart diet
	GUS: Voiding good volumes.
	IV: Jelco patent. [signature] (RN).
21/6/93	CNS: Pain free - mobilising to toilet c̄ no
1730.	ill effects.
	CVS: Monitor SR. 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 [signature]
	Transferred to ward 10 @ 1730 [signature]
21.6.93	Pt resting in bed. Mobilised x1 to
0005h	ensuite toilet - experienced slight tightness
	in chest but eased when she returned to bed
	Pt [illegible] - instructed to ask for pain over-
	night. Nil further episodes
	of chest pain. [illegible] patent. [signature]
22/6/93	0440hrs Rested quietly during the
	night. Nil c/o SOB / chest pain. IV ung
	infiltrated & resited. [signature]

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
22/6/93 0610hrs	0610: Pt stated she had mobilising to toilet x 2 1/2 no problems — [illegible signature]
22-6-93	DAY REPORT - Comfortable day n/s mobilizing as per program. JELCO Patent. Obs stable appetite food. no pain or SOB on attending to ADL'S. Visited by family. [signature]
22.6.93 2245	Pt mobilising as per regime. No c/o chest pain. IV cannula patent. Sleeping [illegible]
23/6/93	0500hrs Resting quietly overnight. not c/o pain or S.O.B IV Bung appears patent [signature]
23.6.93	TFT T3U 0.35 0.3 - .48
	T4 50 60-150
	FTI 18 20-72
	TSH 45 < 5
	→ hothyroid
	[signature]
23-6-93	DAY REPORT - Comfortable day n/s. Tolerated 5 min walk with no ill effects. Jelco infiltrated & removed at 1200hrs. visited by family. [signature]
23-6-93. E/R.	2150hrs - Patient Remained mainly at Bed Rest this shift - ambulating to toilet - NO S.O.B this shift - or N/C pain this shift - S. [illegible] (EN)
24.6.93	0430hrs Rested for long periods On Day 5 of MI Regime today - [signature]

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00119

P111

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
24.6.93	Hypothyroidism – start thyroxine 100 mcg Daily
	Dietry advise from dietician
	Enzymes confirm small MI No sign ECG changes
	For Cardiac post MI rehab ? Home Sun / Mon
24.06.93	Pt has been RIB this shift;
1530hrs	mobilized around ward & assistance, has had
	n/c of chest pain or SOB, has
	mainly been self caring (RN)
24/6/93 2200hrs	Ambulant around ward area only barrier walk
	not attended this shift due to business of ward.
	No complaints pain or SOB. (Enrolled Nurse)
25.6.93	0430hrs Awake to void only ml 90 offered.
25.6.93	Chest pains on mobilisation
	No sign LVF BP 110/60 P60
	pains relieve O2 or GTN
	Add Inderal 60 mg Daily
	Try to achieve Once daily
	regime ? Home Sunday? Mon
	Sub max exercise ECG Next week.

INPATIENT PROGRESS NOTES

00120

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
25/06/93 1515.	Incepudent with nil problems Taken for walk as per Cardiac Regime (Up & down 2 flights stairs & around carparks etc. On return to ward complained of tightness in neck & across chest. O_2 applied @ 6L/min via face mask ECG attended. Tightness eased whilst ECG being taken. O_2 ceased. No further problems this shift Pt has remained RIB not moving very much. Cardiac Tapes & reader given to pt but not listened on as yet. OT requested to see pt prior to discharge JHarvey RN (HARVEY)
25/06/93	Good evening. Monitored (including BPs) according to Cardiac regime & no ill effects. Pts states. watching football on T.V. at present. ———
26.6.93	0430hrs Rested well overnight, nil c/o pain when awake to Jad.
26/06/93	1330 hrs. Good day. Monitored according to cardiac regime & no ill effects. E.C.G. attd to. ———
26/06/93 2200hrs	Quiet evening spent mainly RIB watching TV 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 TV Programmes Encouraged to do so in the am. ——— JHarvey RN (HARVEY)
27.6.93	0430hrs. Rested well overnight.
27-6-93	D/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 — JC. Williams RN
27/6/93 2125	Pt has spent shift mainly RIB watching T.V. Cardiac tapes listened to & Cardiac literature given. ——— JHarvey RN (HARVEY)

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00121

P111

INPATIENT PROGRESS NOTES

(Affix Patient Identification Label Here)

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
28.6.93	0430hrs Rested well, nil c/o overnight – [illegible]
28.6.93	Dr Tinn WR
	Inf MI.
	to thyroxine, [illegible]
	Past Hx MI 5yrs ago
	OPD Dr Tinn 6/52
	R/pt TFT 4/52
	[signature]
	Anginine 5/L i prn
	Aspirin i 150mg daily
	Atenolol 50mg mane
	Imdur i 60mg mane
	Thyroxine i 100mg daily
	Miconazole top 1 squirt bd
28/6/93	O/L pt discharged to home —— K.W[illegible]

INPATIENT PROGRESS NOTES

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00122

INPATIENT MEDICATION CHART

Admission

From..../..../..... To..../..../.....

P111

Admission Weight.....**Kg**

AVOID ERRORS: Drugs will not be administered without a written, legible, complete prescription.

ADVERSE DRUG REACTIONS	DRUG	MONTH/YEAR	NATURE OF REACTION
	N/K		

ONCE ONLY (AND PREMEDICATION) DRUGS

DATE	TIME	DRUG	DOSE	ROUTE	DOCTOR	GIVEN BY	TIME GIVEN
18/6	1840	Aspirin	300mg	PO			1841
24/6	Noon	THYROXINE	50mcg	PO			1510

DRUGS WITH VARIABLE DOSE

DRUG			**ROUTE**	
DATE	TIME	DOSE	DOCTOR	NURSE

DRUG			**ROUTE**	
DATE	TIME	DOSE	DOCTOR	NURSE

INPATIENT MEDICATION CHART

REGULAR PRESCRIPTIONS	**SURNAME** Pill	**VEN NAMES**

DRUG / REACTIONS (See front of Sheet)	ADMINISTRATION TIMES (According to Hospital Policy) 1993	FOR DRUGS NOT GIVEN INSERT (According to Hospital Policy) R REFUSED, S STARVING, A ABSENT, N NO STOCK

00123

RECORD OF ADMINISTRATION

Date → / Time ↓	18/6	19/6	20/6	21/6	22	23	24	25/6	26	27	28/6	29	30

DRUG N/Saline
ROUTE: IV | DOSE: 5ml | FREQ.: q6h | START: 18/6
DOCTOR: [signature] | Pharmacist:

Time	18/6	19/6	20/6	21/6	22
0600	/	[initials]	[initials]	JM	[initials]
1200	/	[initials]	[initials]	–	[initials]
1800	/	[initials]	[initials]	[initials]	[initials]
2400	[initials]	[initials]	/	[initials]	

DRUG Aspirin ½ x 300 mg
ROUTE: O | DOSE: 150mg | FREQ.: daily | START: 19/6/93
DOCTOR: [signature] | Pharmacist: [initials]

Time	18/6	19/6	20/6	21/6	22	23	24	25/6	26	27
0730	\	[initials]	[initials]	JM	[initials]	[initials]	[initials]	GH	[initials]	KU

DRUG Atenolol
ROUTE: O | DOSE: 25mg | FREQ.: o.d. | START: 20/6.
DOCTOR: [signature] | Pharmacist:

Time	18/6	19/6	20/6	21/6	22	23	24
0600	/	/	1130 [initials]	JM	[initials]	[initials]	[initials]

[signature]

DRUG MICONAZOLE below breasts
ROUTE: TOP | DOSE: 1 squirt | FREQ.: BD | START: 21-6
DOCTOR: [signature] | Pharmacist: [initials] 21/6

Time	18/6	19/6	20/6	21/6	22	23	24	25/6	26	27
0830	/	/	/	/	[initials]	[initials]	LN	GH	✓	✓
1800	/	/	/	✓	[initials]	[initials]	GH	[initials]	✓	

DRUG ATENOLOL ½ x 50 mg
ROUTE: PO | DOSE: 25mg | FREQ.: BD | START: 24.6
DOCTOR: [signature] | Pharmacist: [initials]

Time	18/6	19/6	20/6	21/6	22	23	24	25/6
0600	/	/	/	/	/	/	/	[initials]
1800	/	/	/	/	/	/	GH	[initials] ← last dose

DRUG THYROXINE
ROUTE: PO | DOSE: 100mcg | FREQ.: Daily | START: 25.6
DOCTOR: [signature] | Pharmacist: N.

Time	18/6	19/6	20/6	21/6	22	23	24	25/6	26	27	28/6
0600	/	/	/	/	/	/	/	[initials]	[initials]	[initials]	[initials]

DRUG IMDUR
ROUTE: PO | DOSE: 60mg | FREQ.: Mane | START: 25.6.93
DOCTOR: [signature] | Pharmacist: [initials]

Time	18/6	19/6	20/6	21/6	22	23	24	25/6	26	27	28/6
0600	/	/	/	/	/	/	/	[initials]	[initials]	[initials]	[initials]

REGULAR PRESCRIPTIONS	SURNAME P111	GIVEN NAMES
DRUG REACTIONS (See front of Sheet)	ADMINISTRATION TIMES (According to Hospital Policy) 00124	FOR DRUGS NOT GIVEN INSERT (According to Hospital Policy) **R** REFUSED **A** ABSENT **S** STARVING **N** NO STOCK

RECORD OF ADMINISTRATION

1993

	Date → / Time ↓	26/6	27/6	28/6	29	30
DRUG ATENOLOL	0600	D	D	D		
ROUTE PO · DOSE 50mg · FREQ. Mane · START 26.6.93						
DOCTOR · Pharmacist						
DRUG						
ROUTE · DOSE · FREQ. · START						
DOCTOR · Pharmacist						
DRUG						
ROUTE · DOSE · FREQ. · START						
DOCTOR · Pharmacist						
DRUG						
ROUTE · DOSE · FREQ. · START						
DOCTOR · Pharmacist						
DRUG						
ROUTE · DOSE · FREQ. · START						
DOCTOR · Pharmacist						
DRUG						
ROUTE · DOSE · FREQ. · START						
DOCTOR · Pharmacist						
DRUG						
ROUTE · DOSE · FREQ. · START						
DOCTOR · Pharmacist						

SURNAME P[illegible] **GIVEN NAMES**

00125

PRN ADMINISTRATION				Date	Time	Sig.	Date	Time	Sig.	Date	Time	Sig.	Date	Time	Sig.
DRUG Panadol															
ROUTE O	DOSE 1g	FREQ. q4h	START 18/6												
DOCTOR [signature]			Pharmacist												
DRUG Anginine															
ROUTE SL	DOSE ½ – i	FREQ. prn	START 18/6/93												
DOCTOR [signature]			Pharmacist												
DRUG Morphine															
ROUTE IV	DOSE 2.5mg	FREQ. prn	START 18/6/93												
DOCTOR [signature]			Pharmacist												
DRUG Maxolon															
ROUTE IV	DOSE 10mg	FREQ. q8h	START 18/6/93												
DOCTOR [signature]			Pharmacist												

INPATIENT DISCHARGE PRESCRIPTION

U.R. No.: D.O.B. Wt.:

Patient's Name: ______________________

Address: ______________________

____

Doctor's Name: *(Please Print)*

Date

Cas.:

Ward/Clinic:

	Days Reqd	Pharmacy

M.O. SIGNATURE: ....

J169/10—W147—Govt. Printer, Qld.

BUNDABERG BASE HOSPITAL

NURSING CARE RECORD

P111

MEDICAL DIAGNOSIS MI

00126

DATE	SURGICAL/MEDICAL PROCEDURES
18/6/93	IV Jelco (R) hand
23/6/93	I.V Removed.
	26/6 ECG please

DATE	PATHOLOGY/X-RAY REQUESTS
18/6/93	CXR
	CEX 2 o2 ✓
	FBC U+E CEX3
26/6	E.C.G.

DATE	SPECIAL INSTRUCTIONS
22/6	Q'ly TPR & BP BD
22/6	L & S BP 0600
22/6	Daily Weigh 0600
27/6	Listen to Cardiac Tapes.

DATE	SPECIAL NEEDS
	PHYSIO
	SOCIAL WORKER
	OCCUP. THERAPY
	OTHERS

DATE	DIET
18/6/93	H. Heart

00127

BUNDABERG
BASE HOSPTIAL

NURSING TRANSFER / DISCHARGE SUMMARY

P111

Consultant Mc Donnelly

P.H.O. Dr M. TAYLOR

Ward 10

ADMISSION DATE 18/6/93

DISCHARGE DATE 28/6/93

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

M.R. 93

NURSING TRANSFER / DISCHARGE SUMMARY (Cont'd)

00127

Further Comments:

Nurse's Report:

R.N. Signature Kuttan RN