PERSONAL DATA SHEET

AH 313854
MISS RACHEL
HERLIHY F

SURNAME: Mr./Mrs./Miss .....

FIRST NAMES.....

DATE OF BIRTH.....

HOSPITAL NUMBER :– 313854

ADDRESS.....

.....

OCCUPATION.....

RELIGION..... RC

GENERAL PRACTITIONERS NAME & ADDRESS:–

..... Ashurhurst .....

.....

.....

.....

.....

NEAREST RELATIVE OR FRIEND?

NAME..... Marie (mother) .....

ADDRESS.....

.....

Tel. No. to be used in emergency –

SPECIAL INFORMATION EG. SENSITIVITIES

.....

.....

.....

.....

.....

.....

PATIENT'S BLOOD GROUP

GR. ..... H.R. .....

ENTERED BY :–

IN THE EVENT OF DEATH:–

DATE AND TIME.....

.....

CAUSE OF DEATH:–

(i) (A).....

DUE TO (B).....

DUE TO (C).....

(ii) .....

.....

IN-PATIENT TREATMENT

	DATE ADMITTED	WARD	DATE DISCHARGED	DIAGNOSIS	OPERATION/TREATMENT
1	7/6/01	CHW			
2					
3					
4				RF - FAMILY	

068a-047-270

Surname FERGUSON Hosp. No. AH 313854
Forename RACHAEL Ward ALTNAGELVIN AED
Year of Birth 04/02/1992 Sex F Consultant MR L A MCKINNEY

Profile FBC Department Haematology

1/1 7/6/2001 Acc no : 349

Hgb	Hct	WBC	MCH	MCHC	RDW	PLT
11.7	.335	9.06	29.5	34.9	12.4	339

WBC	LY	M	E	BA
9.06	3.18	0.51	4.	0.48	0.04

<CR> to Quit / <P>revious / <N>ext / <L>atest

sortres Inquiry Press <PF1><PF3> For Help

RF - FAMILY

068a-047-271

AFFIX LABEL OR ENTER (IN BLOCK LETTERS)

SURNAME Rachel.

FIRST NAME(S) Ferguson.

DATE OF BIRTH 4/8/92

HOSPITAL NO.

WESTERN HEALTH and SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

SURGICAL

CLINICAL NOTES

DATE	
	Surgical Ward Round
4/6/01	Periumbilical pain started at 8 PM. pain is constant, shifted mainly to R. Right iliac fossa. no vomiting. She had her dinner at 5.10 p.m. no appetite & sat at the meal. had Bowel motion this PM — soft. no urinary symptoms.
PMH	no asthma, no heart problem, no epilepsy no operations
Med.	— nil
Allergy	no known drug allergy
Soc Hist	lives with parents
F.H	no history of anesthetic problem. Heart disease in the family
Syst	no sore throat no chest symptoms

SCS 42

RF - FAMILY

068a-047-272

DATE

9.6.0(

Called to see patient
- H/O Appendicectomy. Headache, vomiting
- Had fit ? Sec to electrolyte imbalance ? Meningitis.
- Pt is on intubation, being monitored. Right upper & lower limb fixed. Pupils dilated & fixed.
- Pt is in ICU
- Resuscitation being carried out
- NGT
- Catheter
- Repeat urea & Electrolytes,

Impr:
Fit sec. to Electrolyte imbalance / Meningitis
Urgent CT scan is organized.

AESTHETIST Dr-GUND.

RGEON

IGHT 25K	HEIGHT	BSA
	HR	TEMP.
E	PREMEDICATION	
X: M☐ F☐		

AH 313854

FERGUSUN

[redacted]

REANAESTHETIC EVALUATION:

Parent Not available at the moment.
Aya-maa PJ. herself.
had dinner at 5:10 P.M. (solids).

:VS
VAD.

RS
NAD.

No significant Past history
to knowledge.

CNS
Conscious oriented.
Talked to mother in OTarea.

METABOLIC
negative Past history
Counseled for Paracetamol suppository.

MOUTH / AIRWAY Loose canine (Lower Rt.)
MP-I.

ASA Status: 1 2 3 4 5 E

HAEMATOLGY

BIOCHEMISTRY

URINANALYSIS

ECG

CXR

DRUG USE :

SMOKING: ☐ NO
☐ YES _____

DRUG ALLERGY :
? NIL

Pt. to be taken ayt 11.00 p.m.

PLAN R ANAESTHESIA : GA E intubation.
Paracetamol suppository 500mg.
Parents to be informed about.

signature : [signature] date : 7/6/01

PERIOPERATIVE EVENTS :
Prolonged Sedation due to opioids.

POST OP. RECOVERY :
Routine Obs.
Analgesics as prescribed

signature : [signature] date : 8/6/0

RF - FAMILY

068a-047-274

[redacted]

AH 313804

FERGUSON

Surn [redacted]

Firs

Hos

Consultant

O.F. 49

SURGEON'S REPORT

SURGEON ..... Mr. Makar .....

ASST. .....

ANAESTHETIST ..... Drs. Jamison, Gund .....

OPERATION PERFORMED

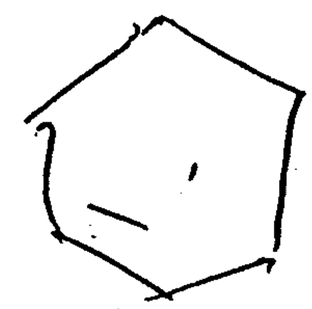
Appendectomy

FINDINGS

Mildly congested appendix.
Focal clotted intraluminal
peritoneal clear fluid reaction
no medial deviation at Mc Burs ± 3 feet of small Bow

DESCRIPTION OF PROCEDURE

Grid min incision
muscle splitting
ligation of mesoappendix
ligation of Appendicular base 2/0 vicryl
purse string suture 2/0 vicryl
pelvic suction
Wound closed in layers using 2/0 vicryle
skin closed with 3/0 vicryl Rapid



Flagyl. 200 mg Tid I.V today then PO/PR suppo

Local anesthetic
5 ml of Marcain 0.25%

NAME OF NURSE TAKING CASE ..... S/N V. Ayton .....

SIGNATURE: Vivienne Ayton

NAME OF NURSE CHECKING SWABS ..... S/N McGrath .....

SPECIMEN FOR HISTOLOGY: (YES) NO

DELETE THAT WHICH DOES NOT APPLY

COMPLETED BY SURGEON SIGNATURE ..... R Makar .....

DATE ..... 7/6/01 .....

LPC 8/85/041

RF - FAMILY

068a-047-275

AFFIX LABEL OR ENTER IN BLOCK

SURNAME

FIRST NAME(S)

DATE OF BIRTH

HOSPITAL NO.

SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

SURGICAL

CLINICAL NOTES

DATE

8/8/01 Ant appendicectomy
Bx of skin. Angiectof
Gen Ex obviously

2

9.6.01 J Johnston 0315
Called to see regarding Rt
Day 1 postop ? appendicectomy.
Unresponsive for 5-10mins ? contractions
flexion of upper limbs
Not classical tonic-clonic
Assoc urinary incontinence.
Unresponsive to 5mg diazepam IV.
Given Diazemuls 10mg

o/e Apyrexial 36.
Still unresponsive due to diazepam
P 80bpm regular rhythm normal character +
volume. Resp ⊖ hs I+II+ nil
Chest clear good ae. Vescular BS.

nb No known history of epilepsy
Fit postop complication
? 2° vomiting + electrolyte abnormality.

DW PRHO urgent check EP, Ca^{2+}, Mg^{2+}, FBP ☐

ECG ☐

✓ By reg/consultant Jeremy Johnston ~~JEREMY JOHNSTON~~

SCS 42

DATE

9.6.0[illegible]

Called to see patient
- P/O Appendicectomy. Headache, vomiting
- Had fit ? Sec to electrolyte imbalance ? Meningitis.
- Pt is on intubation, being monitored. Right upper half
- P/A - Soft Pupils dilated & fixed.
- Distended
Resuscitation being carried out
- NGT
- Catheter
- Repeat U&E & Electrolytes

Impr:
Fit Sec. to Electrolyte imbalance / Meningitis
Urgent CT scan is organized.

IF PATIENT ADMITTED OR REFERRED TO OUT PATIENT'S, THIS COPY TO PATIENT'S CASENOTES.
IF PATIENT NOT ADMITTED OR REFERRED, DESTROY THIS COPY.

Altnagelvin Area Hospital
Accident & Emergency

TRIAGE CODE	DATE/TIME	CHI NO.	A&E NO.
3	7/6/01 2001		01 / 19050
	INCIDENT: Unwell.	SOURCE:	
	NEXT OF KIN:		
	G.P.: Dr Ashenhurst		

SURNAME: FERGUSON SEX:
FORENAMES: MISS RACHAEL
A&E NO AH 01AE19050
04/02/82
[redacted]
HOSP NO. AH 313854
STATUS 11d61134

COMPUTER CODES	
TRIAGE	
DOCTOR	
NURSE	
ADMIN.	

TEMP.	TRIAGE NOTES
36°C	Abdominal pain
PULSE	sudden onset.
B.P. 126/76	
RESP.	

NURSE MMcGeough TIME 9.05 pm

CONSULTANT: McKinney/Steele | SEEN BY DR. Shelly | TIME 8.05 pm

HISTORY/EXAMINATION & DIAGNOSIS/TREATMENT

wt approx 26 kg.
C/O sudden onset of abd pain
~4.30pm
↑ abd pain since
Nauseated
vomiting

DH
PMH
Nil of note
Allergies

HAEMATOL	
BIOCHEM	
BACTERIOL	
X-RAY	
E C G	
OTHER	

X-RAY REQUEST:

LMP
IGNORE A POSSIBLE PREGNANCY? YES NO
RADIOGRAPHER

TO EXCLUDE:

X-RAY INTERPRETATION

DIAGNOSIS: Appendicitis ? Surgeons

TREATMENT

TETANUS TOXOID
COURSE
BOOSTER

DRUG TREATMENT DISPENSED	ROUTE	DOSAGE	TIME/FREQ.	PRESCRIBED BY	DISPENSED BY
Cyclizine	IV	1mg	1 am		

Pt to be followed by surgical team under Mr Mulcahy pt

FINAL PLACEMENT	
DISCHARGE	
REFER TO GP	
REFER OP	
REVIEW A&E	
ADMIT WD:	6
DNW/CTA	

DR'S SIGNATURE & TIME

NURSING ADVICE ETC/GIV.
Home Med 6

NURSE SIGNATURE & TIME

RF - FAMILY

068a-047-278

AFFIX LABEL OR ENTER (IN BLOCK LETTERS)

SURNAME Rachel.

FIRST NAME(S) Ferguson.

DATE OF BIRTH 4/02/92

HOSPITAL NO.

WESTERN HEALTH and SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

SURGICAL

CLINICAL NOTES

DATE	
4/6/01	

Surgical SHO Review.

Rev umbilical pain started at 4 PM.

pain is constant, chiefly mainly to R.

RyM clear fasces.

no vomiting

She had her dinner at 5.10 p.m.

no appetite & ead at the moment.

Last Bowel motion 4 pm — 6 hours.

no urinary symptoms.

PMH no asthma, no heart problem, no allergy

no operations

Med. — nil

Allergy no known drug allergy

Social lives with parents

F.H no history of similar problem

Heart disease in the family

Syst no sore throat

no chest symptoms

SCS 42

RF - FAMILY

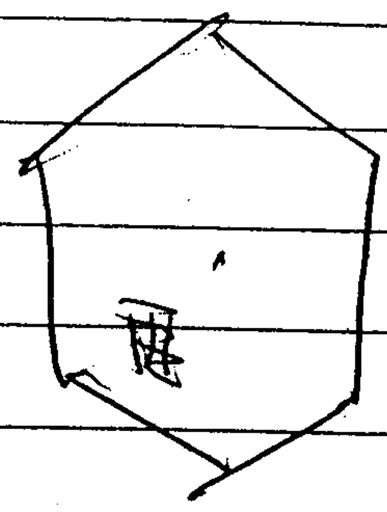
068a-047-279

DATE

o Ex. Apycain
p. 100/- Bp 126/76

chest → clear
Heart → WNL
C.V.S → Grossly intact
Throat → Not congested
Slight Enlarged Tonsils

Abdomen →
Tenderness in epigastric
Mc Burney's point



Tender Right Iliac fossa
→ Guarding
mild rebound
mildly tender on percussion

7/6/01
Hg - 13.7
PC - 3.6
[illegible] - 107
[illegible] 22
[illegible] - 4.8
[illegible] - 7.2
[illegible] - 47
[illegible] - 69
#6 - 11.7
MSC - 9.06
Plat - 339.

Bowel sounds → normal

Pain → acute Appendicitis / obstructed Appendix

Plan → Fasting
I/V Fluids
Consent ✓ done.
Appendectomy

RF - FAMILY

068a-047-280

ALTNAGELVIN HOSPITALS HEALTH & SOCIAL SERVICES TRUST

CONSENT FORM

MEDICAL OR DENTAL INVESTIGATION, TREA[redacted]ATION

Patient's Surname ..... Ferguson ..... [redacted]

Other Names ..... RAchel ..... [redacted]

Date of Birth ..... Hospital Number ..... Sex : *(please tick)* Male ☐ Female ☐

DOCTORS OR DENTISTS *(This part to be completed by doctor or dentist. See notes on the reverse).*

Type of operation, investigation or treatment for which written evidence of consent is considered appropriate.

..... Appendectomy .....

.....

I confirm that I have explained the operation, investigation or treatment, and such appropriate options as are available and the type of anaesthetic, if any (general/local/sedation) proposed, to the patient in terms which in my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient.

Signature ..... R Makan ..... Date : ..... 7/6/01 .....

Name of doctor or dentist ..... R Makan .....

PATIENT/PARENT/GUARDIAN

1. **PLEASE READ THIS FORM AND THE NOTES OVERLEAF VERY CAREFULLY**

2. If there is anything that you do not understand about the explanation, or if you want more information, you should ask the doctor or dentist.

3. Please check that all the information on the form is correct. If it is, and you understand the explanation, then sign the form.

I am the patient / parent / guardian *(delete as necessary)*

I agree
- to what is proposed which has been explained to me by the doctor/dentist named on this form.
- to the use of the type of anaesthetic that I have been told about.

I understand
- that the procedure may not be done by the doctor/dentist who has been treating me so far.
- that any procedure in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.

I have told
- the doctor or dentist about the procedures listed below I would **not** wish to be carried out without my having the opportunity to consider them first.

.....

.....

Signature..... M FERGUSON .....

Name.....

Address.....
(if not the patient)

Date.....

LPC 04/98/008

RF - FAMILY

068a-047-281

Anaesthetic Record

Altnagelvin Area Hospital

DATE 7/06/01

Procedure Appendicectomy.

Dr. GUND / Dr. Jamison.

Primary Technique

- Inhalational / IV ☑
- Spinal ☐
- Epidural ☐
- Local ☐
- Sedation ☐

Monitors

- ECG ☑
- BP ☑
- O2 analyser ☑
- Agent analyser ☑
- Steth pre/ oes ☑
- Capnograph ☑
- Pulse Oximeter ☑
- N-M blockade ☐
- Temp. _____ ☐
- CVP _____ ☐
- Art _____ ☐
- PA catheter ☐
- urinary catheter ☐
- other _____)
- Warming blanket
- Fluid warmer

TECHNIQUE

Retrospective note dated 13/6/01.
Patient only received 200mls of noted fluids below when in theatre.
Nitre bag removed prior to leaving theatre

C Jamison (SHO).

witnessed by

Fluids total
Hartmann's 1L.

Blood Loss

Signed:

Airway — O N
Laryngeal Mask
Intubation — O N
Size 6.0

No ETT/Airway
ET
blind
fibreoptic
awake
rapid sequence

Easy / Mod / Diff

Bain
Circle
Humidifier
O2 supplement
RR 16 x TV 280
Paw 13.

IV Cannula
#22G.

Position

DNDENSERON	2mg.																		
Fentanyl	25+25mg.																		
PROPOFOL	100mg.																		
Scolin	80mg.																		
CYCIMORPH	10 1/2ml.																		
MIVACURIUM	2mg.						1mg.												
Metrogyl	250mg.																		

TIME 11.30 R

220 200 180 160 140 120 100 80 60 40 20

BP – V ^
HR – ●

SAO2						98	97	97											
ETCO2						43.	45	44											

ANAESTHETIST Dr - GUND.

SURGEON

WEIGHT 25K	HEIGHT	BSA
BP	HR	TEMP.
AGE	PREMEDICATION	
SEX : M ☐ F ☐		

AH 313854

FERGUSON

[redacted]

ASA Status: 1 2 3 4 5 E

PREANAESTHETIC EVALUATION:

Parent Not available at the moment.
Informed PA. herself.

CVS
NAD.

had dinner at 5:10 P.M.
(solids).

RS
NAD.

No significant Past history
to the knowledge.

CNS
Conscious oriented.

Talked to ~~Rasc~~ mother in OT area,
negative Past history
Counseled for Paracetamol
suppository.

METABOLIC

MOUTH / AIRWAY Loose canine (Lower Rt.)

MP - I.

HAEMATOLGY
WNL

BIOCHEMISTRY

URINANALYSIS

ECG

CXR

DRUG USE :

SMOKING: ☐ NO
☐ YES _____

DRUG ALLERGY :
? NIL

Pt. to be taken after 11.00 p.m.

PLAN FOR ANAESTHESIA :

GA C intubation.
Paracetamol suppository 500mg.
Parents to be informed about.

signature : Vijay · date : 7/6/01

PERIOPERATIVE EVENTS :

Prolonged Sedation due to
opioids.

POST OP. RECOVERY :

Routine Obs.
Analgesics as prescribed

signature : Vijay date : 8/6/01

RF - FAMILY

068a-047-283

WESTERN HEALTH AND SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

PAEDIATRIC

SURNA AH 313854

FIRST FERGUSON

DATE (

HOSPI

DAT

CLINICAL NOTES

9/6/01 Paeds Jnd term SHO

writing

0620

Jyr 1 Surgical Pt.
Post appendicectomy D1
Vomiting today
No diarrhoea No temp.

Fairly stable until ~ 03[00]
— tonic seizure + bed wet
NAD
given 5mg PR diazepam
10mg IV "
lasted ~ 15 mins

Called to see patient ~ 0415

Pt. looks very unwell
Unresponsive
Pupils dilated + unresponsive
Apyrexic BM = 9
Face flushed + widespread red
macular rash
Petechiae neck + upper chest
↳ probably 1° vomitus
HR 160 min
Sats 97% 100 mask

PCS 9

RF - FAMILY

068a-047-284

Patient Name and Details

Rachel
Ferguson.

PAEDIATRIC UNIT
ALTNAGELVIN AREA HOSPITAL

Date:

DATE	TIME	TEMP.	PULSE	B/P	RESP. RATE	Pain Rating Score	Analgesia given	Signature	COMMENTS
7/6/01	9.59	36.6	93	103/61	24	0-1.		D'Parker.	C/O slight central abdominal pain on admission. Colour pale.
	1.55am	36.7	100	96/49	24	0	—	D'Parker	Sleeping but easily roused. Return to bed. Wound site satisfactory.
	2.15	36.8	96	94/48	24	0	—	D'Parker	Sleeping. Wound site Satisfactory. Colour pink.
	2.35am		90.	85/45.	20.	0	—	ANoble	Asleep @ present. Colour pink. W/site satisfactory.
	3am	37.	84.	78/41.	20	0	—	ANoble	W/site ✓. Child asleep. Colour ✓.
	3.30am		80.	83/47.	20	0	—	ANoble.	well settled W/site Satis ✓ IVI ✓.
	4am.		82	83/57	20	0	—	AN.	W/site satisfactory. n/c pain IVI ✓.
	5am	37.2.	103	93/45.	20	—	—	An	n/c pain Colour good W/site ✓ IVI ✓.
	7am	36.2	89	94/49	22	—		JHenvill	Asleep ✓ colour good. Wound site satisfactory IVI ✓
	9am	36.9	100		24	—	—	MRuce	N/C C/O pain. colour good No ooze from wound site
	1pm	36.6	90		22			AR.	Not c/o pain
	5pm	36.9	92		20			DR	Asleep.
	21.15	35.9	101		21			Stachnik	Colour flushed → pale. Vomiting ++. C/O headache.

RF - FAMILY

Q.6.01.

068a-047-285

WESTERN HEALTH and SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

OBSERVATION SHEET

Date	Time	Pulse	B.P.	Observations
7.6.01.	8pm		126/76.	c/o abdominal pain. Onset approx 6pm. Tender ++. c/o pain on urination. no vomiting. Colour Pale o/A bloods ✓
		36°C.		
	2020	88	109/74.	Cyclimorph. 2mg IV.
		SpO_2	100%.	

[redacted] AH 01AE19050

Pat [redacted]

Ho [redacted]

RF - FAMILY

068a-047-286

ALTNAGELVIN HOSPITALS HEALTH AND SOCIAL SERVICES TRUST

SHEET NUMBER FC.69

FEED CHART

AFFIX LABEL OR ENTER (in Block Letters)

Surname: Leone Peyton

First Name(s)

Hospital No. 313854

FEED COW MILK NORMAL DIET

DATE	TIME	FOOD	AMOUNT REQUIRED IN 24 HOURS	AMOUNT REQUIRED EACH FEED	AMOUNT TAKEN	VOMIT
8/6/01	10.25am					LARGE VOMIT

WESTERN HEALTH and SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

OBSERVATION SHEET

Date	Time	Pulse	B.P.	Observations
9/6/01.	3-05am			Child found on side having been incontinent. Appeared agitated and face + neck flushed - Hands tightly clenched + teeth. O2 @ 15l/min + nasopharyngeal 5mgs Diazepam given pr. - Steel filling - 10mgs diazepam given IV - Lasted approx 15 minutes
		HR 76	T37.6	
	3.15am		SaO2 99%	Cold to touch: Still agitated. EP, Calcium + Magnesium taken. O2 continued via face mask.
	3.30am	T36.6		
	4.10am	124	104/73	
	4.30am			BM 9.7 mmol/s.

RF - FAMILY

AH 318804

F MISS MELANIE F

FERGUSON

H [redacted]

C

068a-047-288

Date	Time	Prob. No.	Evaluation	Signature	B.O.	Communications/Instructions/Investigatio
9/6/01.	10.10pm		New patient age 9yrs Rel R/C. from WD 6 at Tamw with history as follows.			
Fully attended Confirmed by RE Mull on			- admitted to WD 6 on 7/6/01 C abdominal pain. No past medical history. S Appendectts. Appendix removed Thursday night = mildly inflamed — No problems during op. on 8/6/01 — no concerns — Vomited x 6-7 times during day - was able to walk. NO temps			
			diarrhoea.			
			Check by nurses 3am, — incont urine - unresponsive - tonic. seizure HR ↑ 160. Received 5mg Diazepam P.R. 10mg IV diazemuls. — Seizure lasted 15mins Bloods FBP/U+E/Ca/Mg/ Cultures taken.			
			4.10 am. Very unwell. Pupils dylated. + unresponsive HR ↑ 160 min. Resp. Rash Petechia upper chest ? 2° Vomiting. ? Asp. SaO2 98% Intuicially 98% 08L O2 but sats ↓ quickly + became apnoeic Intubated C Anaesthetist Size 6 ETT orally (No drugs given prior to intubation).			

Name: Racheal Ferguson Hospital Number: AH.313854 Ward: Icu

151647 HC5

RF - FAMILY

068a-047-289

EVALUATION SHEET

Date	Time	Prob. No.	Evaluation	Signature	B.O.	Communications/Instructions/Investigations
			Ventilated — Fluids changed to 0·9% NACL			
			500 @ 40ms HR.			
			1M MGSO4			
			2·4mg IV Cefotaxime. } 5am.			
			1·2 mg IV Benzylpenicillin given }			
			Catherized size 10 foley (5ml water)			
			CT Scan ordered.			
			(Initially sub-achnoid haemor found.			
			C. evidence ↑ ICP. — Transferred to.			
			ICU 7am Ventilation commenced via			
			SERVO.			
			Repeat CT Scan. — taken 9am.			
			Obs. (see chart) stable:			
			G.C.S 3. — Unresponsive Pupils			
			Large fixed: + dilated.			
			Bed available in Sick Children's RVH.			
			Racheal fully attended | Family informed			
			Aware of condition — RVH by ambulance			
			+ police escort. 11·10am.			
			1½ · eventful journey to Belfast Arrived 12·20 PM S/N [illegible]			
			Neg balanced 1L Obs satisfactory			
			Hypothermic. T 33·5 on departure @ RVH.			
			FBP COAG EP Bone Profile MgSO4 sent.			
			Results given & staff in Sick Children.			

068a-047-290

RF - FAMILY

Name: Hospital Number: Ward:

AH 313854

MISS RACHAEL

FERGUSON

F

[redacted]

DOB/AGE:

ADMITTED:

WD/DIS:

CONSULTANT:

DRUG TREATMENT SHEET

DRUG ALLERGY / CORTICOSTEROIDS /

PREVIOUS RELEVANT THERAPY

Age	Sex	Weight (Kg)
9yrs	F	25 Kgs

Date Admitted 7/6/01

Discharged/ Transferred

	Date Treatment Started	Approved Name of Drug (Block Letters)	Dose	Route	Special Instructions	Indicate Prescribed Times by a Tick 6.00	8.00	12.00	14.00	18.00	22.00	24.00	Signature of Prescriber	Cancelled Date	Cancelled Initials
1	7/6/01	DICLOFENAC	12.5	PR.	S hrly								[signature]		
2	7/6/01	PARACETAMOL	500 mg	PR	8 hrly								[signature]		
3	7/6/01	Flagyl	500mg	P.R	TID		—		—	—			[signature]		
4															
5															
6															
7															
8															
9															
10															
11															
12															
13															
14															
15															

RF - FAMILY

068a-047-291

Unit No.	Surname	Christian Name(s)	Consultant
313854	Ferguson	Rachael	

SPECIAL RECORDING SECTION FOR PREMEDICATION DRUGS GIVEN

Date	Premedication Prescribed	Dose	Time Given	Signature of Prescriber	Signature of Administer

ONCE ONLY DRUGS

Date	Approved Name of Drugs (Block Letters)	Dose	Route	Special Instructions	Signature of Prescriber	Time Given	Given By (Full Signature Please)
7/6/01	9. MORPHINE 1mg/ml upto 5mg.		I/V.	in RECOVERY	Vijay Lalf.		
7/6/01	ZOFRAN 4mg	2 mg	I/V	9/ Reyd.	Vijay Lalf.		
7/6/01	DICLOFENAC.	12.5mg	PR.	in Theatre	Vijay Lalf.	11.40pm	MMC Gralen
7/6/01	PARACETAMOL	1000mg	PR	in Theatre	Vijay Lalf.	11.40pm	MMC Gralen
8-6-1	~~Valoid~~	25mg	IV	STAT	MCm		
9.6.1	Valoid	25mg	IV	STAT	MCm	10-15pm	MCm
9.6.01	DIAZEPAM	10mg	IV	STAT	J Johnston	0315	J Johnston
9.6.01	DIAZEPAM	5mg	PR	STAT	J Johnston	3.05	J Johnston
9/6/01	Magnesium sulphate 50%	1ml	left buttock	IM (=2mmol)		0520	
9-6-01	CEFOTAXIME	2.5g	IV		J Johnston	0520	given at 0500 by Dr Johnston
9-6-01	BENZYLPENICILLIN	1.2g	IV		J Johnston		

068a-047-292

RF - FAMILY

PARENTERAL DRUGS

	Date	Approved Name of Drug (Block Letters)	Dose	Route	Special Instructions	Indicate Prescribed Times by a Tick 6.00	8.00	12.00	14.00	18.00	22.00	24.00	Signature of Prescriber	Cancelled Date	Cancelled Initials
A	7/6/01	CYCLIMORPH. '10'	1/4 CM	I/M	6 hrly PRN.								Vijay [illegible]		
B	~~7/6/01~~	~~Metronidazol (Flagyl)~~	~~200 mg~~	~~I.V/P/S~~	~~8 hrly~~								~~[illegible]~~		
C	~~7/6/01~~	~~ZOFRAN~~	~~2 mg~~	~~I.V.~~	~~8 doses~~								~~[illegible]~~ Dr.	Dr.	7/6/01
D	8.6.01	~~CEFOTAXIME~~	~~2.5 g~~	~~IV~~									~~[illegible]~~		
E	8/6/01	~~BENZYLPENICILLIN~~	~~1.2 g~~	~~IV~~									~~[illegible]~~		
F															
G	9/6/01	CEFOTAXIME	1.2 g	IV	50mg/kg 8 hrly	✓			✓		✓		[illegible]		
H	9/6/01	Benzylpenicillin	1.2g	IV	50mg/kg 8 hrly	✓			✓		✓		[illegible]		
I															
J															
K															
L															
M															
N															
O															
P															
Q															
R															

RF - FAMILY

068a-047-293

15½ x 11½ 150920

Unit No.	Surname	Christian Name(s)	Consultant
31365[illegible]	[illegible]	[illegible]	

DRUG ADMINISTRATION RECORD (Continuation)

RECORD FOR REGULAR PRESCRIPTION DRUGS AND "AS REQUIRED" DRUGS GIVEN AT STANDARD TIMES										RECORD FOR "VARIABLE DOSE" DRUGS AND AS "REQUIRED DRUGS" GIVEN AT **NON**-STANDARD TIMES					EXCEPTIONS TO PRESCRIBED ORDERS REASON
Date	For Review	6	8	12	14	18	22	24		Enter Reference Letter/Number, Time Dose (if variable) and Initial your entry					
8/6/01				3 NJ			3 AW			1+3 at 8.05 pm	2e 9.30pm AW.				

NOTES ON PRESCRIBING AND ADMINISTRATION

PRESCRIBING

1. Please use approved names BLOCK LETTERS Metric Dosage.
2. Please ensure that the correct section is used for each prescription.
3. Place a tick in the appropriate time columns when treatment is to be given at these times.
4. Please sign your name against each prescription.
5. When changing prescriptions make sure that you cancel with a single straight line those drugs which are to be discontinued, and complete the cancelled section with date and initials.

ADMINISTRATION

1. The senior nurse must ensure that a record is made on the patients Drug Administration Record every time a drug is administered, by entering the initials of the nurse giving the dose. in the appropriate box.
2. Nurse must check carefully to see that all drugs prescribed for a certain time are administered.
3. If a drug is refused enter reference number/letter and circle it e.g. ② or Ⓐ
4. If a patient is absent enter reference number/letter and draw a diagonal line through it. e.g. 8 or M
5. If drug not given for reasons other than 3 and 4 above enter reference number/letter and draw a cross through it e.g. X or M
6. **N.B.** Always enter reason for **Non** Administration of a Drug in the "Exceptions to Prescribed Orders" Column.

GENERAL

1. External preparations should be prescribed on this record in the relevant section. The Nurse should make a record of applying or administering external preparations by the same method as internal preparations.
2. **Antibiotic prescriptions are valid for seven days only unless otherwise specified.** Therapy should be reviewed after seven days unless otherwise specified.

RF - FAMILY

068a-047-294

150923 8 1/4 x 11 1/2

Unit No.	Surname	Christian Name(s)

ALTNAG[illegible]VIN HOSPITAL NEO NATAL IN[illegible]NSIVE CARE UNIT
FLUID BALANCE FOR I.V. FLUIDS

Name Raesai Fogwon. Date 3/10/0. Wt. Age 9yrs. **FB**

	INPUT												OUTPUT										
SPECIFY FLUID	NaCl 30ml/hr								INTRAVENOUS		ORAL		ASPIRATE	VOMIT	URINE		STOOLS	LAB SUGAR	HAEMOCUE	Signature	I.V. SITE	Commen
	1		2		3		4		5		6											
TIME	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Amt.	Amt.	Total	Total					
08.00	150	30												vomit						[illegible]		
09.00	150	180																				
10.00	150	240												large vomit	PU.					VMR		
11.00	150	320																		VMR		
12.00	150	400																		VMR		
13.00	150	480												vomited ++						L AL		
14.00	150	560																		MVV		
15.00	150	640												vomited ++						VMR		
16.00	150	720																		VMR		
17.00	150	800																		NAL		
18.00	150																					
19.00	150	960																		VMR		
20.00	150	1040																		NM ✓		
21.00	150	1120												vomiting coffee grounds ++						Stricket ✓		
22.00	150	1200												vomited dark amount x3						Stricket ✓		
23.00	150	1280												small amount coffee ground vomit						Stricket ✓		
24.00	150	1360																		NP ✓		
01.00	150	1440																		F.D ✓		
02.00	150	1520																		Stricket ✓		
03.00	150	1600																				
04.00	150	1680																				
05.00																						
06.00																						
07.00																						

Intravenous Total	
Oral Total	
TOTAL INTAKE	

Urine Total	
Other Total	
TOTAL OUTPUT	

RF - FAMILY

068a-047-295

25 kg

40
20
5

Maint = 65 ml/hr
213 maint = 40 ml/hr

PARENTERAL NUTRITION FLUIDS PRESCRIPTION SHEET

	Amount (ml)	TYPE OF FLUID	NAME and AMOUNT of ADDITIVES	Rate ml/hour	Type of pump	Serial number of pump	Prescribed by (Signature)	Batch No. Date of Expiry	Time erected + erected by (Signature)
1	1000	Soh 18.		80	IMED 960	11445	dBut.	212003 01C19 BB	~ MRice S/N ~ 12.10. Ahills/N.
2	1000ml	0.9% Nacl		40					
3									
4									
5									
6									
7									
8									
9									
10									

LPC 01/85/064

RF - FAMILY

068a-047-296

PARENTERAL NUTRITION FLUIDS PRESCRIPTION SHEET

	Amount (ml)	TYPE OF FLUID	NAME and AMOUNT of ADDITIVES	Rate ml/hour	Type of pump	Serial number of pump	Prescribed by (Signature)	Batch No. Date of Expiry	Time erected + erected by (Signature)
1	1 litre 80ml/Hour	No 18	—	80ml/Hr	1100	11445	R Mah.	01C1988 2/2000	10.15a Dr Hasan / Bajwa
2									
3	[illegible]								
4									
5									
6									
7									
8									
9									
10									

LPC 01/85/064

RF - FAMILY

068a-047-297

ALTNAGELVIN HOSPITAL NEO NATAL INTENSIVE CARE UNIT
FLUID BALANCE FOR I.V. FLUIDS

Name Rachel Ferguson Date 7/6/01 Wt. ..... Age 8 years

FB

	INPUT								INTRAVENOUS				ORAL		OUTPUT											
SPECIFY FLUID	1		2		3		4		5		6				ASPIRATE	VOMIT	URINE		STOOLS	LAB SUGAR	HAEMOCUE	Signature	I.V. SITE	Comment
TIME	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Total			Amt.	Amt.	Amt.	Total	Total					
08.00																								
09.00																								
10.00																								
11.00																								
12.00																								
13.00																								
14.00																								
15.00																								
16.00																								
17.00																								
18.00																								
19.00																								
20.00	18																							
21.00	Bonbilw																							
22.00	100	—																						
23.00	150	60																				DP —		
24.00	At Theatre.																							
01.00													Fasting											
02.00	150	140																						
03.00	150.	220																						
04.00	150	300																						
05.00	150	380																						
06.00	150	466																						
07.00	156	540																						

Intravenous Total	
Oral Total	

Urine Total	
Other Total	

RF - FAMILY

068a-047-298

ALTNAGELVIN HOSPITAL

Name	: FERGUSON,RACHAEL
Sex	: F
D.O.B.	: 04/02/1992
Hosp.No	: AH 313854
Source Loc	: ALTNAGELVIN HOSPITAL
Ward/Clinic	: WARD 6
Cons/GP	: MR R GILLILAND

Received : 08/06/2001
Lab.Ref : 0105206

Copy to :

Specimen : APPENDIX

Secretary :- COK

CLINICAL HISTORY:

Right sided abdominal pain of 6 hour duration and tenderness and guarding.
Peritoneal fluid reaction.

PATHOLOGIST'S REPORT:

Received a 6 cm long appendix which grossly appears normal. On section, there is a faecolith 1 cm from the proximal margin. (4 BL NTR).

Histology of the entire appendix confirms the presence of a faecolith and Gram Stains show Gram Positive Cocci within the faecal material. There is no mucosal ulceration in the sections examined and there is no acute inflammation within the mucosa. In a few sections, there are occasional eosinophils and an occasional polymorph within the muscle layer but no plasma cells are seen. The serosal surfae shows no acute inflammation.

DIAGNOSIS:

APPENDIX : FAECOLITH

BS

Signed:

Date : 19/06/2001

Pathologist:DR J CROSBIE (Altnagelvin Hospita

Histopathology Report WHSSB Dept. of Pathology

RF - FAMILY

068a-047-299

SURNAME Ferguson
FIRST NAME(S) Rachael
DATE OF BIRTH
HOSPITAL NO. AH 313854.

SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

INTENSIVE CA

CLINICAL NOTES

DATE	
9/6/01	A. Date (Anaesth).
8.30.	
	fast bleeped to Rod 6 @
	~F/8yr. had appendicectomy ↓ GA the night before.
	-Had been vomitting during the d Suddenly started to fit during → had a convulsions → ~~Airway~~ & Sats maintained but suddenly SaO_2 ↓ to 80s & stopped breathing
	On my arrival → pt was cyan SaO_2 ~ 70% Apnoeic.
	IPPV c bag & mask SaO_2 improved to ~ 80%
	but vomiting +
	∴ Intubated c No 6.0 cuffed tube → cuff +
	Copious dirty secretions → su c
* ↓ Na. ↓ Mg.	Rest of My → as per paed notes cro gastric tube +
	C.T. scan ? Subarachnoid haemorrhage.
	Neurosurgeons informed → want a contrast C.T. scan to rule out

abscess in the brain
Taken back to the C.T scan for contrast C.T Scan

↓

no new findings.
Neurosurgeon contacted →
Nothing surgical seen on the scan
~~-Not for to~~
-But for transfer to RBHSC when bed available.

May contact Dr Hanna for advice ~~as for is~~ on call for paed neurology at RBHSC.

Back to ICU

On Dräger Ventilator Servo 300 ventilated
200 X 8 FiO_2 50%
SpO_2 100% Chest clear

HR → 93/- BP 105/62 S,S

U o/p → 100-400ml/hr
Na ↓

Plan:- for transfer to RBHSC when bed available
:- ↑ Na gradually over 24 hrs
- Cefotaxime & benlen given
- IVF → 1000ml (N) saline } 40ml/hr.
+ 40mmol KCl

DATE

9th JUNE 01. EMERGENCY CT. OF HEAD.

There is evidence of a SUB-ARACHNOID haemorrhage with raised intracranial pressure.

NO focal abnormality demonstrated.

Consr. Dr. C. MORRISON.

8.30AM. RE-Scanned at the request of N.S.U., R.U.H.

To exclude a Subdural empyema?

CT. OF HEAD.

An enhanced scan was performed. No evidence of a Subdural empyema.

Consr.

SU [redacted] FERGUSON

FI

DA

HC

WESTERN HEALTH and SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

PAEDIATRIC

CLINICAL NOTES

DATE	
09/06/01	Retrospective note
06.15	Recalled to see
	9yr. old - post-op appendectomy
	- vastheas / cyanotic / tonic posturing — ? decerebrate.
	→ received PR + IV Diazepam
	- looked unwell / collapsed + unresponsive
	→ dilated fixed pupils.
	- Airway/Motor assessment → IPPV.
	— fundi: sharp / pupils unreactive / unresponsive
	Urgent CT brain / (N) verbally. Discharge → recalled by pm
	Fluid restrict / ↓ sodium maintenance fluids. low BMg ??
	[redacted] Ward / Liv (≡ Y3 maintenance)
	Fr ICU. Fr skeletal / electrolytes correct.

DJE

Q. ferguson 0430 9/6/01

5651
OV
14.5
0°C
467
1.0
41

HCO3	16.1
TCO2	16.8
BEI	4.8
SBC	21.3
BEecf	-7.8
%sO2c	99.4

UNITS
Gas mmHg
B.P. mmHg
Hb g/d

0430 9/6/01

Na 118 Mg 0·59
K 3
Urea 2·1 Calcium 2·19
creat 43 alb 41
gluc 11
Hb 12·1
Wcc 17 — N=1
Plat 319 R1

TRANSFER RECORD SHEET

Patients Name: RACHEL FERGUSON Hospital No: A&E 313854

Date: 9th June 2001 Time of Departure: 11.10 am.

PATIENT INTERVENTION / MONITORS:

Tracheal Intubation: Yes / (No)
Ventilated (Manual) Yes / (No) – Size of E.T.T.: 6.0
(Mechanical) (Yes) / [redacted] – Type of Ventilator: Oxford Portable
Central Venous Lines – Mode of Ventilation: SIMV / IPPV.
E.C.G. Yes / (No) C.V.P. Monitoring Yes / (No)
Blood Pressure (Direct) (Yes) No SAO_2 (Yes) / No
(Indirect) Yes / (No) $ET CO_2$ Yes / No
Chest Drain (Yes) / No Urinary Catheter (Yes) / No
Yes / (No)

Time	11.10 AM	11.20 AM	11.30 AM	11.40 AM	11.50 AM	12 MD	12.10 PM	12.20 AM				
H.R.	105	105	104	103.	105.	103	103	104				
Rhythm	SR	SR	SR	SR.	SR	SR	SR	SR.				
B.P. (Cuff. NIBP)	96/47	96/47	94/50	93/47	98/50	99/46	97/46					
C.V.P.	N/A	N/A.	N/A	N/A.	N/A.	N/A	N/A	N/A				
SAO_2	100%	100%	100%	100%	100%	100%	100%	100%				
Insp. O_2												
Resp. Rate	10.	10	10	10	10	10	10					
Tidal Volume	200	200	200.	200.	200	200	200.					
Airway Press.	+18	+16	+16	+16	+16	+16	+16					
Peep cms H_2O	+2	+2	+2	+2	+2	+2	+2					
ET CO_2	34	34	34	34	34	33.	35.					
PUPILS	E	E	E	E	E	E	E					
Right Size	7	7	7	7	7	7	7					
Right Reaction	F	F	F	F	F	F	F					
Left Size	7	7	7	7	7	7	7					
Left Reaction	F	F	F	F	F	F	F					

SIZE OF PUPIL
1
2
3
4
5
6
7
8

FLUID	VOL.	STARTED AT	RATE	SIGNATURE
NACL + KCL	1L	9am	Home	[redacted]

DRUG	DOSE	TIME	SIGNATURE

Time of Arrival: 12.20 pm.

Any Important Episode of: Desaturation Hypotension

Tick if journey uneventful: ✓

Arrhythmia Hypertension Other

If Yes, Please elaborate:

Evaluation

[redacted]

AH [redacted]

Surn [redacted]

Firs

Hos

Consultant

O.F. 49

SURGEON'S REPORT

SURGEON Mr. Makan

ASST.

ANAESTHETIST Drs Jamison, Gund

OPERATION PERFORMED

Appendectomy

FINDINGS

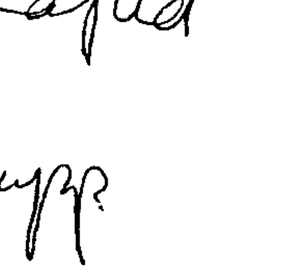
Mildly congested appendix.
Fecalith intraluminal
peritoneal clear fluid reaction
no nodal distention at ileal loop ± 3 feet from BJ

DESCRIPTION OF PROCEDURE

Gridiron incision
muscle splitting
ligation of mesoappendix
ligation of appendix base 2/0 vicryl
purse string 2/0 vicryl
pelvic suction
Wound closed in layers using 2/0 vicryle
skin closed with 3/0 vicryl Rapid

local anesthetic
5ml of Marcain 0.25%

Flagyl 500mg IVI today then PO/PR supp



NAME OF NURSE TAKING CASE S/N V Ayton

SIGNATURE: Vivienne Ayton

NAME OF NURSE CHECKING SWABS S/N McGeath

SPECIMEN FOR HISTOLOGY: YES NO

DELETE THAT WHICH DOES NOT APPLY

COMPLETED BY SURGEON

SIGNATURE R Rahim

DATE 7/6/01

LPC 8/85/041

RF - FAMILY

068a-047-305

ESTERN AREA HEALTH & SOCIAL
ERVICES BOARD

ALTNAGELVIN GROUP OF
HOSPITALS

4 HOURLY T.P.R. CHART

Month June

Affix Label
or Enter in
Block Letters
Full Name
Hospital No.
Ward
Consultant

Rachel Ferguson
DOB 4/2/92
Hosp No 313854

SHEET No. T

DAY	7	8th										
DAY OF DISEASE												
	A.M. 2 6 10	P.M. 2 6 10	A.M. 2 6 10	P.M. 2 6 10	A.M. 2 6 10	P.M. 2 6 10	A.M. 2 6 10	P.M. 2 6 10	A.M. 2 6 10	P.M. 2 6 10	A.M. 2 6 10	P.M. 2 6 10
TEMPERATURE °F												
107 °												
106 °												
105 °												
104 °												
103 °												
102 °												
101 °												
100 °												
99 °												
98 °												
97 °												
96 °												
95 °												
PULSE 150												
140												
130												
120												
110												
100	105											
90												
80												
70												
60	61											
50												
45												
RESPIRATION 40												
35												
30												
25												
20												
15												
10												
5												
WEIGHT	25 kgs											
STOOLS												
AMOUNT OF URINE												
VOMITING												

RF - FAMILY

068a-047-306

Intra – Operative Nursing Care

Time into Theatre /

Patient Position:

		Arms	
Supine	..... ✓	Right	Left
Prone	.....	☐	☑ At side
Lateral	.....	☑	☐ Armboard
Lithotomy	.....	☐	☐ Other
Other	.....		

Tourniquet:

Yes ☐ No ☑

Site .....

Pressure .....

Time On .....

Time Off .....

Pressure Relieving Aids:

None .....

Type .....

Site .....

Moving Aids:

Easy Glide ☐

Multiglide 2 way ☐

Multiglide 1 way ☐

Other ☐

Warming Blanket:

Yes ☐ No ☑

Temp. Setting .....ºC

Comments: Voltarol supp 12.5 mg } @ 11.40 pm.
Paracetamol " 500 mg } @ 11.40 pm.
Marcain 0.75% 5ml to wound

Surgeon:	**Assistant:**	**Scrub Nurse:**	**Checking Nurse:**
Mr. Makar		S/N V. Ayton	S/N M McGrath

Swab/ Instrument Counts:

	Taken before incision			Correct at closure	
	Yes	No		Yes	No
Raytex Swabs	✓			✓	
Packs	✓			✓	
Tonsil Swabs					
Needles	✓			✓	
Scalpel blades	✓			✓	
Instruments	✓			✓	
Tapes/ sloops					
Other					

Surgeon Informed

Yes ☑

No ☐

Wound Closure:

Clips ☐ Sutures ☑

Packs Left Insitu:

(specify)

Drainage:

Prosthesis/ Implants:

Type:

Site:

Signature/ Title: .....M McGrath.....

Theatre Nursing Care Plan

AH 318854

MISS RACHAEL F

FERGUSON

[redacted]

Date: / / 7-6-07.
Time: / 11.20pm
Procedure(s) .....
.....Appendicectomy.
.....
.....

Allergies
None Known ☑
Yes (specify) ☐
.....
.....

Mobility Impairment
None ☑
Yes (specify) ☐
.....
.....

Special Needs
Hearing .....
Sight .....
Language .....
Prosthesis .....
None ☑

Skin Integrity
Healthy .....
Reddness .....
Raised Temp .....
Discoloured .....
Broken areas .....

Level of Response
Alert ☑
Drowsy ☐
Asleep ☐
Premedicated
Yes ☐
No ☑

Throat Pack
Yes ☐ No ☑
Time In.....
Time Out .....

Risk Score .....

Comments :

	Yes	No	Comment
Identity band present	✓		
Consent form signed	✓		
Operation site marked		✓	
~~Crowns~~/ loose teeth	✓		Bottom Right
Dentures/ plate removed	N/A		
Drains/ catheters insitu		✓	
Blood grouped			See notes
Blood crossmatched			

Venupuncture site.....Right arm.....
IV infusion site .....
Arterial line .....
C.V.P. site .....

	Yes	No
Cricoid Pressure	☑	☐
ECG Monitor	☑	☐
Oxygen Monitor	☑	☐
Co2 Monitor	☐	☐

Flexoplate Applied Yes ☑ No ☐
Bipolar
Site .....Right thigh.....

Anesthetist ; Drs Jamison Grund

Type of Anaesthetic (please specify)

1 Local ☐
.....

2 General ☑
oral tube 37.0

3 Regional ☐
.....

Controlled Drugs Used :
Fentanyl } I.V. @ induction
Cyclimorph }

Signature/ Title : MMC Grund

RF - FAMILY

068a-047-308

Recovery Area Care

Post Operative Recovery Position:			
	Yes	No	Comment
Airway Control	✓		
Suction Applied	✓		
I.V. Infusion Chkd.	~~N/A~~		To be recommenced on ward.
Catheter Drain Chkd.	N/A		
Drains (other) Chkd.	N/A		
P.V. Loss	N/A		
Wound Chkd.	✓		
Cast Chkd.	N/A		

Skin Integrity:

Healthy	✓
Redness	
Raised Temp	
Discoloured	
Broken Areas	

Oxygen Administration:
Prescription Method

Initially in recovery.

Analgesia:
Drug Given: Route: Time:

Comments

OBSERVATIONS

	Am		Pm		Am		Am		Am
Time	12.45		12.55		1.05		1.15 Am		1.30
Level of Conciousness	asleep		asleep		asleep		awake		awake
Response to Stimulii	yes		yes		yes		yes		yes
Breathing Spontaneously	yes		yes		yes		yes		yes
Airway	ET Tube		ET Tube		clear		clear		clear
Oxygen Saturation	99%		99%		99%		99%		99%
Respiratory Rate			24		18		20		18
Blood Pressure	117/65	/	102/72	/	105/57	/	116/66	/	/
Pulse	116		109		108		111		117
Peripheral Circulation	good		good		good		good		good
Pain	—		—		—		—		—
P.C.A./ Epidural Commenced	—		—		—		—		—
Recovery Nurse Signature	MMC Gwatkin				**Ward Nurses Signature**				

ALTNAGELVIN HOSPITALS HEALTH AND SOCIAL SERVICES TRUST
TRANSFER REFERRAL SHEET

Patient Name: RACHAEL FERGUSON Hospital No: AM 313854

Date of Admission: 7/6/01 Ward: Wd 6

Present Location: ICU

Principal diagnosis: INITIAL - APPENDICITIS
~~CEREB~~ ? MENINGITIS ? ENCEPHALITIS

Reason for Transfer: TO BMED ICU BELFAST

Time of decision: 09.00 (CONFIRMED)

Referring Consultant : DR NESBITT

Receiving Consultant : DR. CREAN

Results of Relevant Investigations: ? Sub. achnoid haem.

Current Drug Therapy: 2.4 mg IV Cefotaxime } TDS
1.2 mg IV Benzylpenicillin }
Nil else.

CHECKLIST:

Family informed: Yes / No Was patient full attended: Yes / No

ITEMS TO BE SENT WITH PATIENT:

Case Notes: - Originals Yes / No X-Rays - Originals (Chest) Yes / No
- Copies: Yes / No - Copies Yes / No
CT X Rays (Not sent) Faxed ag

Patients Belongings: Yes / No

Signature: NP Dooher S/N

RF - FAMILY 068a-047-3H0

ALTNAGELVIN HOSPITALS
HEALTH AND SOCIAL SERVICES TRUST

AFFIX LABEL OR ENTER (In Block Letters)

Surname
First Name(s)
Hospital No.

MOUNT SHEET

RADIOLOGICAL REPORTS

ALTNAGELVIN AREA HOSPITAL
DIAGNOSTIC IMAGING DEPT.

REQUEST TO THE RADIOLOGIST

O/P Ward ..... Consultant Gilliland / MAKER

STA
NHS
Private
Non U.K.
Cat II

To Avoid Shortcoming: This Section Must Be Completed

Name of Patient (In Block) FERGUSON RACHEL

Address [redacted]

D.O.B. 4.12.92 Hos. No. AH3138554

DT.

Date of Last X-Ray 8/6/01

OBLIGATORY

L.M.P.

Ignore A Possible Pregnancy

Yes No

Examination Requested

Xray Chest

Date 9/6/01 Doctor's Signature ondell

Clinical Data

POST APPEN DICECTOMY
RESPIRATORY COLLAPSE
~~?. SEPSIS~~
CEREBRAL EVENT ? NATURE

For Departmental Use Only

Appointment For

Room

Portable.

Films Used

35 x 43
35 x 35
30 x 40
24 x 30
18 x 24

Others

64kV. 1.6mAs. Supine.

Radiographer

AF/EC.

Checked

LPC 9/87/039

XRR. 17

RF - FAMILY

068a-047-311

AFFIX LAB

SURNAME [redacted]

FIRST NAME(S) Rachel.

DATE OF BIRTH [redacted]

HOSPITAL NO. [redacted]

UD/CP . CONSULTANT Ferguson 04/02/92

WESTERN HEALTH and SOCIAL SERVICES BOARD

ALTNAGELVIN GROUP OF HOSPITALS

PAEDIATRIC

CLINICAL NOTES

DATE	
23/3/92	
27/4/92	3/12 old ♀.
	Problem - ? cuic ⓛuip.
	No Fhx CDH
	Normal delivery
	OE - No assymetry
	Full abduction
	No clicks / dislocation.
	NORIV.

PCS 9

RF - FAMILY

068a-047-312

WESTERN HEALTH AND SOCIAL SERVICES BOARD
LONDONDERRY, LIMAVADY AND STRABANE UNIT OF MANAGEMENT

ALTNAGELVIN AREA HOSPITAL

LONDONDERRY BT47 1SB Telephone [redacted]

Dr Ashenhurst
Health Centre
Waterside
LONDONDERRY

23 March 1992

Dear Dr Ashenhurst

RE: [redacted]

[redacted]

Your sincerely

Dr J O'Donnell
SHO in Paeds

sr

WESTERN HEALTH & SOCIAL SERVICES BOARD

ALTNAGELVIN AREA HOSPITAL

LONDONDERRY BT47 1SB

TELEPHONE- LONDONDERRY [redacted]

DATE:

IN CONFIDENCE

Dr Ashenhurst
Health Centre
Waterside
LONDONDERRY

PATIENTS NAME: Rachel Ferguson

ADDRESS [redacted]

DATE OF BIRTH: 04 02 92 HOSP. NO: 313854 DATE OF ATTENDANCE: 27 April 1992

Dear : Dr Ashenhurst

[redacted]

Yours sincerely

Dr A Kinney
SHO in Paeds

sr

ALTNAGELVIN AREA HOSPITAL

LABOUR WARD BABY OBSERVATION CHART

NAME [redacted]

DATE 4.2.'92

SEX Girl.

Wt:- [redacted]

HC:

Length

D.O.B. & TIME 4.2.92 @ 6.55pm

HOSPITAL NO.

OBSERVATIONS - 1/2 hourly x 2 hours Hours x 3-12 hours

TIME	TEMP.	COLOUR	RESPS.	APEX RATE	URINE	MEC.	FEEDING & AMOUNT	COMMENTS
[redacted]								

RF - FAMILY

068a-047-315

WESTERN AREA HEALTH AND
SOCIAL SERVICES BOARD
ALTNAGELVIN GROUP OF HOSPITALS

Affix label or enter

[redacted]

BABY'S WEIGHT CHART

PW. 67

Date [redacted]

Days	D/A	1	2	3	4	5	6	7	8	9	10	11	12	13	14

WEIGHT
Grms.

GAIN

[redacted]

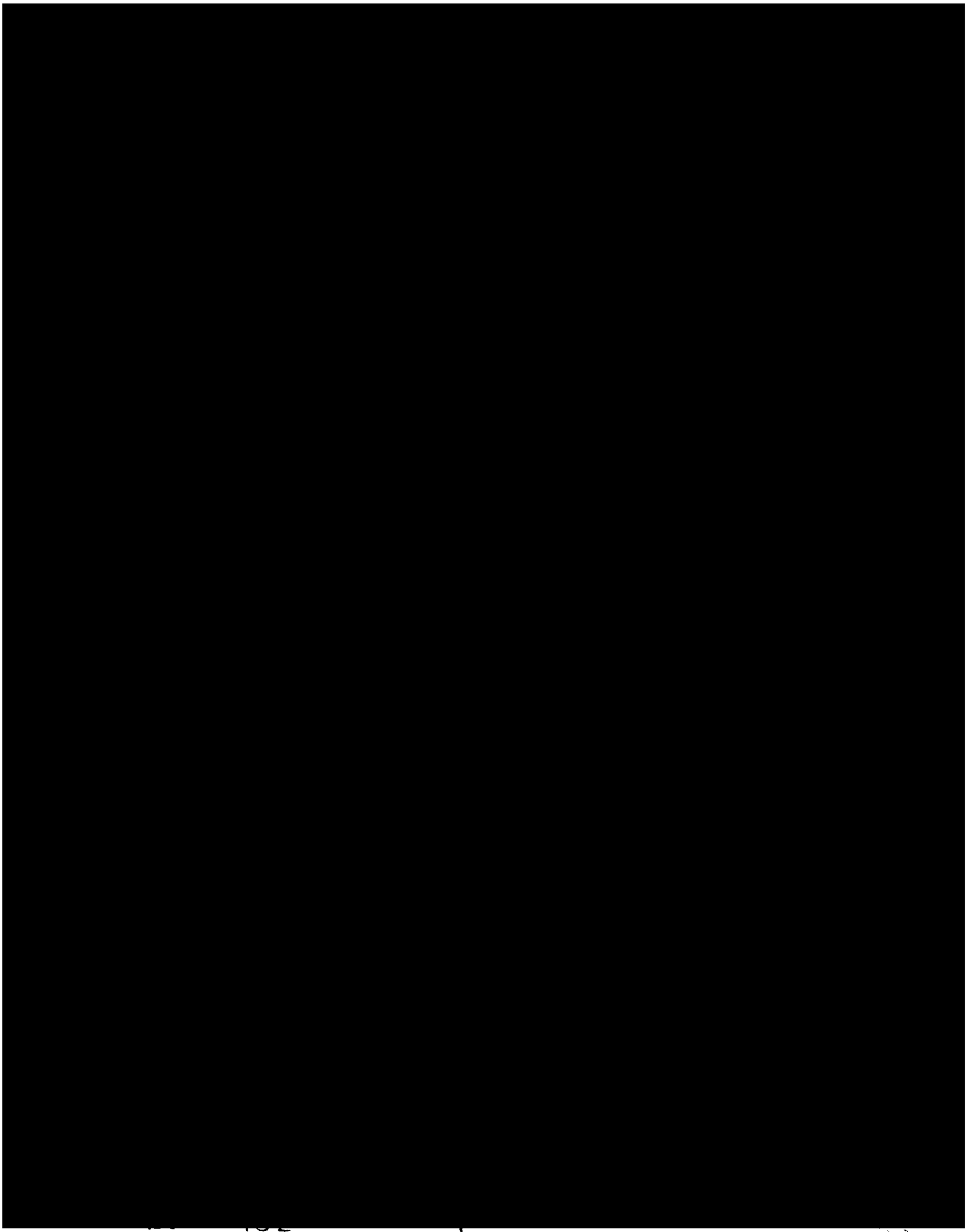
LOSS

[redacted]

Feeding (26 | 16 | 15 | 19

RF - FAMILY

068a-047-316



Northern Ireland Child Health System

Maternal / Neonatal Discharge F

CHS 3

1)

[redacted]

RF - FAMILY

For of

Signed _____ Date

Status

Ward

068a-047-318