THE ULSTER HOSPITAL

CLINICAL NOTES

ROBERTS: CLAIRE U8706831

[redacted]

10.1.87
S

OPD/WARD

Ward: .....

DATE	NOTES
25/2/87	Baby Clinic - V. Gladhill
6/52 wks	Hb. 10-6 Wt 4:12 oz. (9lbs 12 ozs) Length 55.5cm
	Clicky (L) hip
	Feeding well.
	Smiling
	O/E: Good colour
	Chest Clear
	CVS: P 90/— Reg 2H.Ss No murmurs
	~~Abd: Soft~~ ~~N.A.D.~~
	~~Hips V.K.~~ Spine ✓
	Tone ✓ Posture ✓
	See at (6/12) VG
15.7.87	BABY CLINIC Dr. T. BROWN

22/1/46

DATE	NOTES
23/7/87	P/C Convulsion – Febrile x2

HPC

Yesterday morning mother noticed her to be twitching & eyes rolling for a period of 1–2/60 afterwards she was quite well & feeding normally

Then this morning ~~[illegible]~~ her mother once again noticed her to be ~~[illegible]~~ jerking her limbs & eyes again rolling. Mother was not present when episode started but the maximum time from when mother saw her last until the episode stopped was 10 minutes

It continued for ± 3/60 While she was unwell Recent H/o of sticky eyes & green mucus running from nose

No GI symptoms No pulling at ears

PMH

Nil of note

FH

Nil of note

Med^{D}

None.
No allergies

POH

N^{D} @ term.
Immuniz^{n}s up to date.
No comp^{n}s of pregnancy

O/E

Temp 37.4.

P 120 reg
2HS ↑ No (M)

THE ULSTER HOSPITAL

CLINICAL NOTES

Affix label here or enter:

Full Name: Claire Roberts

Unit No.: U87068831

Ward: AIN.

DATE	NOTES
	RS Exp R=L BS- vesicular But harsh on the (R) side. Abd. Soft. Throat - ✓ Lt ear - normal. Rt ear - TM observed by cone. Ix Hb 11.3 ~~11.3~~ 11.8 ~~11.8~~ FBP ~~WCC~~ No Neck stiffness dwcc. Blood cultures. Mx Antibiotics - Amoxil 62.5mg TID Calpol. - 5ml's 4-6hrly PRN Close obs. D. Duffy
24/7/87	in very good form & well Remains Apyrexial. feeding very well occasional cough chest cl. clear Abd Soft CVS Femorals = NB (N) snuffly nose Needing suction for physio.

22/1/46

DATE	NOTES
25/7/87	Improved afebrile - chest Resp BS' Enlarge around + plaster
26/7/87	- Well No Resp. - chest clear - Home today Parent aware RJ 6/52 01.
4/8/87	**OUT-PT. DR. V. GLEADHILL**
AB. 1/52	URINE HEIGHT 56½cm. WEIGHT 15lb 15oz. (7.23kg)
	6 days ago shook & eyes Rolled. Next day further fit - admitted Discharged Sunday Shaking & eyes started Tuesday. Settled. Friday 1.50 pm further attack Started eyes open suddenly shaking → whole body shakes Sleepy cry — then harsh cry. Snuffling. Sat. 5.50 pm. Eyes Rolling fists clenched. Seen by GP Antibiotic changed → Septrin Sunday ✓ Monday 7.0pm. Further similar episodes
	O/E: Good colour Skull HC = 43cms Fontanelle ✓ Tone ✓ Posture ✓ Chest Clear CVS ✓ Abd Soft NAD Admit for observation — USS EEG etc Cal Aa chromatogram VG

THE ULSTER HOSPITAL

CLINICAL NOTES

Affix label here or enter:

Full Name: CLAIRE ROBERTS

Unit No.: U87 06831.

Ward: A/N.

DATE	NOTES
4/8/87.	Admitted from OPD. for investigation of frequent fits. 6/12 old. O Well until ~~2~~ 4 wks ago admitted c ? Febrile convulsion Having nearly 1 fit per day. Lasting 1-2 min. ~~twitching~~ twitching starring. Crying. SO. CVS/RS. Stightly chesty. GIT Appetite. Good. Bowels ✓ GUS No Urinary Symptoms CNS ✓. No known Allergies. Septrin 5mls bd for 3 days PMH. Clicky Hip Immunisation P.O.H. N/D @ Term. No Perinatal Problems FH No EP. SH. 2 brothers 2 + 4 yr. PE. Healthy. not Anaemic. Not Dehydrated CVS. P120 bpm HS I + II No (M). RS. Chest Clear. ABD. Sofr No Masses.

22/1/46

DATE	NOTES
	CNS. RERLA. No facial Asymmetry.
	Moves all 4 limbs
	Tone R=L.
	Posture.
	6/12 ♀ for Investigation of fits.
	Numbers
4.8.87	Admitted from P.O.P. – investigation of? Seizures
	Previous admission 23/1/87 ē febrile convulsion ×2 for first time
	Discharged 26/7/87 – since then generalised shaking ē eye
	rolling for 1–2 mins ē sleepy afterward on 3-4 occasions
	No antiepileptic Rx.
	NO +ve FH
	No head injury known
	No perinatal problems
	No contact ē others, otherwise well
	Gen Sleeping after feed. Appr Good colour
	Not unduly irritable
	CVS HR 140/min 2HS ○M Fem ✓
	RS Clear
	Abd ○↑ 2 KKS Soft.
	Mild napkin rash around vulva.
	CNS Fast asleep! ⊙ = 43.2 cm.
	AF small nonobtensive Tone ✓ limits
	all movements spontaneous Reflexes +/4. all sides
	Pupils equal + reactive
	Fundi not easily seen.
	Plan · observe : Fit chart
	· FBP U+E/Ca (WOODS light
	· Urine → STAT + O+S
	· Cerebral USS, Lateral S/R
	· EEG.
	Reassess developmental status when awake Dietmar

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CLINICAL NOTES

Affix label here or enter:

Full Name: Claire Roberts -

Unit No.: U8406831

Ward: Arcke

DATE	NOTES
5.8.87	Well. Nursing Staff. noticed vacant expression for few seconds on feeding. 1 Episode of being restless + agitated while asleep Otherwise well. Bloods. FBP U+E & Ca. Bl. Sugar. Wood's Light. EEG. FRIDAY. N Taylor
6/8/87.	Well. No Unusual features. Blood & USS Normal N Taylor for examination under Wood's Light. tomorrow am before EEG.
7/8/87	[redacted] Thank you — Wood's light (-) no evidence Tuberose Sclerosis etc is naked eye either 2 Episodes of Absence Attacks. Frozen Animation for 2 sec. Then goes on normally No Twitching. Otherwise well for EEG. this am N Taylor Normal Record.
8/8/87	No further episodes. Continue to observe
9/8/87.	Investigate / U+E / Ca^{2+} (N) / B. Sugar. / CXR (N) - MSSU (N) - EEG (N) - S+R / USS vertebrales (N) - Wood's light (N)

22/1/46

DATE	NOTES
	No further episodes Home today : No medicat. R/V O.P 1/12 " " SP
24.8.87	DR. V. GLEADHILL Boy in convulsion. Has had 6 today. Generalised twitching salivation cyanosis last 10 minute. Has had several times discharge but none for past 3 days until this am. Admit for further assessment Mark TEGRETOL VG
24/8/87.	Re-admitted. Having frequent fits.
4.50 pm.	7 mth old Q Infant. Previous. Admission for investigation of fits. Investigations normal. EEG USS of Head Bloods. Amino Acid Chromatograph Few Absence attacks observed on the ward. Since discharge 1 fit * every 3rd day. Goes stiff extends (Rt) Arm Shakes Goes blue around mouth Salivates Usually lasts 1 mins. Stops spontaneously Irritable + Sleepy afterwards To-day awoke normally. Then had 4 fits. Taken to OP. Had further fit. Seen by Dr Gleadhill. On the ward had 1 further fit. lasted 2 mins stopped spontaneously. SQ. CVS/RS nad Cough. N. SOB. GIT no Vomiting / Diarrhoea. GUS Urine nor ↑ Dysuria. Not Pulling at her ears.

THE ULSTER HOSPITAL

CLINICAL NOTES

Affix label here or enter:

Full Name: Claire Roberts

Unit No.: U84 0 8831

Ward: Aicken

DATE	NOTES
	No Medication No Known Allergies P.O.H. N/D @ Term Br. Wt. No Perinatal Problems Feeding Mixed. Ostermilk + Solids PMH. NAD Immunisation Triple Vaccinations X 2 Up to date FH. ? Cousins ē Epilepsy. Sn. 2 Sibs 4 + 2 yr Healthy. 2 Parents. Gs. Poor Colour. Not Dehydrated. Temp 38.5. No Nodes No Meningism CVS HR 120 bpm HS I + II N. (M). RS Chest Clear. Abd Soft No Masses Fem Pulses. ♀. Throat Clear. TMi. Slightly Red. CNS Tone initially post ictal Rt Arm ↓ Tone. Settled tone R = L.
22/1/46	

DATE	NOTES
	Tx. F&P DWCC.
	U+E Bl.
	Bl. Sugar.
	Ca.
	Astrup.
	Bl. Culture.
	CSF.
	MSU.
	10-15 mg/kg. wt. ÷ 7. kg = 105 mg.
	Rx. Tegretol 5 ml 100 mg orally. Stat.
	3.5 ml. 70 mg bd.
	fits for stabilisation
	· Ascaptic Technique
	L.P. · Clear Fluid obtained needle moved. Blood stained fluids
	· No Complications
	I.V. Cannula. (Rt) Arm
	Observe.
	Wt = 7 kg. Kmbe
	qpr : No fits
	U+E (N) Ca^{2+} (N) Bl sugar (N).
	CSF (N).
	Start Tegretol 10 mg/kg ÷ 2 divided doses &
	↑ gradually
25.8.97.	No further fits.
	Sleepy.
	Developmentally appears normal.
	Repeat. Amino Acid Chromatography
	Kmbe
26.8.97.	Mone settled Less sleepy.
	No further fits.
	In better form
	Temp settled.
	Kmbe
	MSU Ove. Growth No. Pus Cells
	Rx. Co-trimoxazole

THE ULSTER HOSPITAL

CLINICAL NOTES

Affix label here or enter:

Full Name: Clare Roberts

Unit No.: U8406831

Ward: Arch

DATE	NOTES
	USS + X-ray Abd Arranged
	NRyder
27.8.87.	Drowsy.
	Feeding well
	No further fits.
	Dr Gleadhill will speak to parents to-day.
	NRyder
28.8.87.	Less Drowsy.
	Feeding well
	No fits.
	for USS of Kidneys, MSU x 2.
	C.T. as O.P.
	? Home Sunday.
	NRyder
29/8/87	To have bananas.
	No fits observed.
	MBa.
30/8/87.	R/V Fei for Tegretol level
	O.P. ~ 3/52 DP.

22/1/46

THE ULSTER HOSPITAL

CLINICAL NOTES

Affix label here or enter:

Full Name: Jamie Roberts

Unit No.: .....

Ward: .....

DATE	NOTES
2/9/97	8mth old girl readmitted with H/O ~~x4~~ fits ~~today~~ - due to come forward for scan Tegretol tomorrow. Mother anxious + tearful ++ H/O epilepsy - recently I/x in ward + was only discharged 3 days ago Awaiting cat scan as OP. Feeding well today No URTI No bowel problems. Bright + alert today. Fits. lasted ~ brace tonic / clonic cyanosis. lump afterwards. No near FH epilepsy (cousin on maternal + paternal side epileptic) No TB. Drops Tegretol 1.75 mls b.d. O/E Appropriate Bright Fit witnessed - similar to above. Faint haemangioma on forehead. RS Chest clear. Ears + throat - NAD Abd Soft masses. Pulses 100/- reg 2HS ° murmurs femorals ✓ CNS Bright + alert before fit ✓ tone afterwards. ? Developmentally retarded - cant sit up even c support - further assessment

22/1/46

DATE	NOTES
	unsettled on child fitted No persistence of primitive reflexes. Cyclimorph 2.5mg IV diagemuls at 9.30pm. For further 50mg operunti in 20mls Normal saline IV if further fitting. Smitty.
3/9/87.	No further fits. Sleepy this am. No temps. feeding fine Obs/Soe. Tegretol Level. Rubes As above: Tonic/clonic fit x 1 min Has had IV diagemuls + currently on Carbamazepine No cause for fits found. Awaiting CT scan O/E Sleepy - Yawning Babbles + blows bubbles Fixes + follows Turns to sounds well. Head lag +/4. Tone ↓ Reflexes ↓ Plantars ↓↓ Truncal control v. poor No lateral or downwards parachute response. Tongue protrusion at times. CVS ✓ RS ✓ Abd: ? ↑ hepar/spleen D. Convulsion ? cause ? Some developmental delay BUT on tegretol + had diazepam in recent past Lab urine chromatogram → trace MPS — Repeat Bring CT forward Check tegretol level ? Nitrazepam Rudman

THE ULSTER HOSPITAL

CLINICAL NOTES

Affix label here or enter:

Full Name: Claire Roberts

Unit No.: U8706831

Ward: Aicken Nursery

DATE	NOTES
	Talked to Dr Hicks who has kindly agreed to admit Claire to Mulled Ward RBHSC for further assessment VG
	Rather glazed look Tone rather floppy Difficult to assess whether tone equal + ↓ more on (L) Rather inclined to hold (L) arm pronated.
4/9/87.	Sleeping this am Did not rouse Tone ↓ Rt L. side
	Nursing Staff feel that she is not using her Left side as much and movement not as well as coordinated.
	Observe left when awake.
	NTaylor
23.9.87. age 8/12 mth.	BABY CLINIC DR. V. GLEADHILL Wt Lenght

22/1/46

Claire Roberts. Fit Chart.

DATE	TIME	Description NOTES	Signature:
7.8.87	8.30am	2 vacant episodes of staring with 'frozen' movements lasting only ≈ 2 secs.	M. Burbing.

4/4/88 DR. V. GLEADHILL

1 year

URINE

HEIGHT 72.5cm

WEIGHT 20 lbs 14 oz 9.38kg

No fits since September
On Epilim 2.75 mls BD.
Claps hands.
Attending RBHSC — hearing ✓
Improved vocalisation — babbling —
Mum thinks she hears well.
'Dada', but no REAL sounds
Knows hair + toes
Grinds teeth
Waves good-bye.
Sits well. Gets into crawling position + may go backwards
Pincer grip for ~ 9/12
Sitting well since age of 11/12.
Not standing with support.

A bit sick ? Epilim.

O/E: Good colour HC = 46.5 cms
Tone ✓ ✓
Reflexes ✓ ✓
Chest Clear
CVS: P 100/m Two H.Ss No murmurs
Abd: Soft NAD
Not standing — should be at this age

Review (9/12) VG

200mg -400mg

THE ULSTER HOSPITAL

CLINICAL NOTES

ROBERTS CLAIRE [redacted] U8706831

10.1.87 S

Ward OPD/WARD

DATE	NOTES
7.4.88	DR. V. GLEADHILL no fits Progress Epilim 2-75 mls BD crawling bottom walking on alleys grips c both hands feminine, smile at everyone. URINE HEIGHT 73.5 cm WEIGHT 9.6 kgs 21lb 3oz Tone gen slight ↓. no words, plenty of noises. sitting ✓.
9.6.88	DR. V. GLEADHILL See 3/12. ? Dr Majors clinic at some stage DR. V. GLEADHILL UTD. See 9/7
14.7.88	DR. V. GLEADHILL Walking with supported Needs a bit more confidence. Mummy Daddy etc Tries to feed herself. URINE HEIGHT 0.740 m WEIGHT 10.2 kg Mum says she is not as quick as her older two (0's 3's) but she certainly was fairly responsive & waved to me before Mum had finished saying Wave Bye. Bye! I shall ask Dr Major for a fuller assessment

DP 0235 22/1/46

THE ULSTER HOSPITAL

CLINICAL NOTES

Affix label here or enter:

Full Name: CLAIRE ROBERTS

Unit No.:

Ward: M/S

DATE	NOTES
14/7/88 10pm	18/12 old admitted via GP with ? croup ? epiglottitis.
	HPC
	was seen @ O/P clinic c̄ regards to seizures. On Epilim 2.75mls B.D.
	Rubella 2 wks ago.
	well until today - sl. cough in AM, croupy this afternoon + raised temp.
	°allergies °other PMH of note
	O/E Temp. 37.4°C insp. stridor °resp distress °meningism
	Throat ✓ TM ✓✓
	RS. 'rattly' °creps
	CVS. 2HS °M
	Abd NAD
	Δ croup CXR ✓
	Rx Disprol
	moist O2 if deteriorates
	[signature]
15/7/88 12.30 AM	CXR → evidence of consolidat. @ (R) apex
	Rx Amoxil 125mg tid
	[signature]
16/07/88	Well Temp settled
	No stridor Loose cough CXR - (R) UL consolidatn
	Mom very able and keen for discharge
	Home Parental physio + antibiotics
	Ward review Wednesday for repeat CXR
	[signature]

DP O235 22/1/46

DATE	NOTES
20/7/88	Well.
	CXR - resolving consolid[n].
	RE clear
	Ct Amoxil x 10days.
	R/V as arranged by Dr Magors
	A Walle.
9/8/88	DR. V. GLEADHILL
	Mr Adams is satisfied with leaving 24/7/88 - discharged
1 1/2 yrs.	URINE
	HEIGHT 0.780M. ○ 47.5 cms. (Ella)
	WEIGHT 10.88
	3rd child Ulster N/D at term - 7lb 9ozs.
	No neonatal problems.
	Had clicky hip.
	Convulsions began at age 6 mths - total
	~10 over July + August 87. None since Sept 87.
	EEG showed
	Epilim 2.75 mls B.D
	(mummun) (dadi)
	Speech mummy, daddy, [illegible], shoes. away all done
	mother says she waves bye bye + claps hands on verbal request (observed)
	Body parts / hair + shoes ✓
	mother was anxious because she was slow to walk.
	Sat at 10 mths.
	Pulls to stand. ~12mths.
	Walking independently 19mths.
	Feeds herself. c spoon in R hand.

THE ULSTER HOSPITAL

CLINICAL NOTES

ROBERTS CLAIRE U8706831
[redacted]
Unit No.: 10.1.87
OPD/WARD S
Ward:

DATE	NOTES
	Plays appropriately c toys. will brush hair, etc.
	Does not select objects. Bricks o Rings o. mew in
	boat o. Hidden toy yes.
	O/a well.
	Chest clear. Ears NAD Throat NAD.
	ABD NAD.
	CVS 2HS - - - - (normal). F.A.S.V.
	Tone normal.
	See Dec. 19th 9.30AM.
20/9/88	Epilim 2.5 mls B.D. organized by telephone
19.12.88	Dr. T. BROWN
age. 1 11/12.	URINE / HEIGHT '800 / WEIGHT 11.2 kg. — EPILIM 2.5 mls B.D. (mother works extremely well)
	No convulsions since Sept 87.
	General health good
	Appetite good. - beginning to self feed
	with spoon. (fed all family food)
	No bowel upsets
	Words, potty, shoes, Katy, bag book ball. yes. + first words
	Labelled apple, b- for brush. baby, his baby bus
	Communicates by gestures + words, + behaviour lead things

DP O235 22/1/46

DATE	NOTES
	Eye contact with toys well improved.
	Plots rings (incorrect order)
	Men in boat – poor – took put one in + out again
	Shapes trial + error. ? better c D hand.
	Does not select objects on command – does
	eye point to some –. Play c miniatures 0-
	Body parts no improvement.
	Feeds well. – tongue protrudes – ⓒ 48 cms
	Chest clear – Ears NAD. throat
	CVS 2HS No ⓜ. FAN
	ABD NAD.
	Tone normal.
	Hips abduct equally
	① Serum valproic level
	② TFT'S.
	Continue !
	OT See assess clinic
	Speech Afford.
	See physio as well
	Delay in development
	Play ~ 15 mths –.
	Speech) 15 mths +.
29/12/88	TFT's within normal levels
	Serum valproic level 50 mgs/L
8/2/89.	MMR. convulsions do not contra indicate injection

THE ULSTER HOSPITAL

CLINICAL NOTES

Affix label here or write:

ROBERTS; CLAIRE U8706831

[redacted]

10.1.87

F

Ward: Paed OPD/WARD

DATE	NOTES
11.9.89	Dr. T. BROWN Castlereagh Nursery 1991 048-5 cm EPILIM 2.5 mls B.D. SERUM LEVEL = 50 mg/L. URINE HEIGHT 088 cm WEIGHT 12-6 kg ↑ 2 yrs 8 ll not toilet trained. Feeds herself & spoon fed, still pushes dish away. no definite convulsions. 'snorted' in sleep once last July & twice in August, easily wakened usually ? daytime ? minor convulsion General health good – Appetite good. FINE MOTOR Concentration difficult – flits around. Eye contact & toy difficult to achieve Ring. Shapes. replaced if directed +++++. after banging Blocks built 3 & D. SPEECH EXPRESSIVE. no more bricks, no more sandwich, up on knee, cup of tea, Hat's nice, . mimics new words, Communicates by behaviour. Single word vocabulary is good, Labelling pictures good but articulation poor.) RECEPTIVE SPEECH – Plays in moulture, give drink to Mummy (does not understand Teapot Body parts – did not cooperate well – eyes, nose, tongue, teeth, hair,

DP O235 22/1/46

DATE	NOTES
	7/b Lockswell
	Mast clear - Ears NAD Throat NAD
	Seizures clinic
14/9/90	Telephone call -
	1 convulsive seizure last night - (strong shaking yawn + back to sleep)
	Epilim 4 mls B.D.
5/10/90	Serum valproate level 110 mg/L.
8/5/91	Secretary received telephone call re dental: Mrs Platt to speak to mother
10/6/91	Telephone call -
	1 seizure last night —— Parents heard noise
	No stiffness but head twisted - Didn't recognize parents
	Suggest 5mls Epilim BD
	To return for serum valproate level in 2 weeks —— KF
26/9/91	Telephone call -
	9/9/91 1 seizure during S
	13/9/91 general jerking (stiff) tonsillitis.
	16/9/91 general jerking
	26/9/91 Snort, jerking + stiffness + sleeping.
	↑ Epilim 7.5 mls BD.
	To commence above immediately & return for serum valproate level early October
16/10/91.	Serum valproate level = 90-8 mg/L.

WWG 3749

THE ULSTER HOSPITAL

CLINICAL NOTES

UH 87/06831
CLAIRE MARGARET F
ROBERTS
[redacted] 10/01/87
[redacted]
WD/OP CONSULTANT

DATE	NOTES
14.10.91	Dr Major
	Epilim 7.5 mls B.D ie [redacted] 300 mgs B.D
	mother feels that her behaviour has deteriorated. School do Not report any problems
	No convulsions since dose increased
	See 4mths once
	Thurs am please.
	(Detailed in letter to send of)
6.2.92	Dr Major
age 5 yrs	URINE not obtained; HEIGHT 1.040 m; WEIGHT 16.8 kg. Longstone – not making progress. ? Tor Bank – Sept.
	EPILIM 7.5 mls BD
	No convulsions since medication increased in Sept 91.
	NE.
	Serum Valproate = 90.8 mg/L. See 6 mths.

DATE	NOTES
6.8.92 Age 5 7/12	Dr Moyo
	URINE — EPILIM 7.5 mls B.D (sugar free)
	HEIGHT 1062m.
	WEIGHT 18Kg. — SERUM VALPROATE LEVEL = 90.8 mg/L.
	no convulsions since Sept 91.
	1st convulsion at 6 mths
	TOTAL numerous -
	O/A Looks well
	Chest clear Ears NAD Throat
	Continue
	See 6 mths
	* To discuss CT scan + chromosomes at next visit.
	DR. V. GLEADHILL
2.11.93	
age 6 10/12 yr	URINE — Epilim 7.5 mls B.D 300mg. B.D.
	HEIGHT 1132 m
	WEIGHT 19.5Kg.
	2nd year at Tor Bank.
	History = convulsions commenced at 6 mth
	EEG ē normal record.
	No convulsions for 2yrs.
	Last episode Sept 91
	Continue same dose epilim meantime
	(ie reducing it 1/size)

WWG 3749

UH 87/06831
CLAIRE MARGARET
ROBERTS F
[redacted]
10/01/87
Unit No: WD/OP [redacted]
Ward: CONSULTANT

THE ULSTER HOSPITAL

CLINICAL NOTES

DATE	NOTES
	+ consider weaning off Sept 94 if no further convulsions.
	(Last EEG was normal – check again)
	Serum epilim level
	not examined – Chromosomes
	CT Scan
	See 6 mths ē Prof
14/4/93	Serum valproate level 140 mg/L.
	Mrs Roberts telephoned + asked to reduce Epilim
	to 5mls BD. (over a 2 mth period)
22/11/93	Mother telephoned to say that Mr Roberts does not
	want CT Scan – cancel.
9/6/94	DR. J. MAJOR arrange ē Prof Nevin
	assess clinic.
5/11/94	Mother telephoned – have to get MR at school.
	advised that this is should go ahead – but
	she has never had MMR
	Mrs Roberts to ask Dr Jackson RBHSC
	to return to me if any problem.
	DR. J. MAJOR
16.2.95	
age 8½ yrs	URINE / HEIGHT 1192 cm / WEIGHT 19.7 Kgs — Tor Bank School, Mrs Jess
	Epilim 5.0 mls am 7.5 mls pm (200) (300)
	No convulsions since Sept 1991
	EEG would be difficult to perform 23/9/90
	Last one did not show any definite abnormality

CR - ULSTER HOSPITAL 099-059-098

DATE	NOTES
	Looks well altho' pale today
	Chest clear. Fundi not seen
	Advised wean off Epilim gradually
	eg 200mgs BD for 1 mth
	then 100mgs + 200 mgs for 1 mth
	100 mgs BD for 1 mth
	100 mgs nocte for 1 mth then off
	Does not wish CT scan —
	Does wish to see Prof [illegible] No reviews.
	write to City.
30 MAY 1996	DR. C. GASTON PAED. MEDICAL
ap. 9 4/12 yrs	URINE
	HEIGHT 1270cm
	WEIGHT 23.8kg sleeps on
	[illegible]
	53cm
	Difficulties : Scattiness
	and Obsession c paper
	May talk all morning to see her settle.
	Darts everywhere.
	[redacted]
	off Epilim for 1yr...
	[redacted]
	[illegible signature]

CLAIRE ROBERTS
UH 87/ 06831

WWG 3749

THE ULSTER HOSPITAL

CLINICAL NOTES

Affix label here or enter:

Full Name: .....

Unit No: .....

Ward: .....

DATE	NOTES
20 Jan 97	Courtesy discussion with Mr + Mrs Roberts.

WWG 3749

THE ULSTER HOSPITAL

CLINICAL NOTES

ROBERTS; CLAIRE U8706831

[redacted]

10.1.1987 F

OPD/WARD

DATE	NOTES
1 AUG 1996	DR. C. GASTON PAED. MEDICAL Discussion on ADHD & family Suggest trial Ritali if family wish Ritali vs Placebo. 5mg x 2 day } vs 7 days Placebo. 10mg x 5 days } SE discussed.