	Date	Clinical Notes
→		Personal Information redacted by the USI
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		
→		Personal Information redacted by the USI
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		
→		
Age		
Patient 65		Personal Information redacted by the USI
W		
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

HSS TRUST _____ | GP PRACTICE or other _____

Hospital Unit _____ | Primary Care Provider _____

FORM 1 – CONSENT FOR EXAMINATION, TREATMENT OR CARE

Personal details (or pre-printed label)

[redacted] Patient 65

.....

.....

.....

lentifier) .....

.....

.....

Statement of healthcare professional

Responsible healthcare professional .....Job Title.....

Name of proposed procedure or course of treatment *(include side of body or site and brief explanation if medical term not clear)*

[redacted] Personal Information redacted by the USI

I have explained the procedure. In particular, I have explained:

.....

.....

The intended benefits .....

.....

.....

Serious or frequently occurring risks .....

.....

.....

Possible additional procedures which may become necessary during the procedure.

❑ Blood transfusion ❑ other procedure (please specify).....

This procedure will involve: ❑ general and/or regional anaesthesia ❑ local anaesthesia ❑ sedation

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any samples of tissue that may be taken and any particular concerns of this individual.

❑ The following leaflet/tape has been provided.....

Signed .....[redacted] Personal Information redacted by the USI .....Date .....

Name **(Print)** .....Job Title .....

Contact details *(if patient wishes to discuss options later)* .....

Statement of interpreter (where appropriate)

I have interpreted the information above to the person giving consent to the best of my ability and in a way which I believe s/he can understand.

Signed .....Date .....

Name **(Print)** .....

Copy accepted by person giving consent Yes/No (please circle)

Statement of person giving consent

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed the form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about possible additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.

.....

.....

***I agree** that healthcare students, who will be supervised by healthcare professionals, may observe or assist in my care. * *You may remove this sentence without affecting your care.*

Signature [redacted] Patient 65 .....Date .....

Name **(Print)** .....

A witness should sign below if the person is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes)

Signature .....Date .....

Name **(Print)**.....

Confirmation of consent (to be completed by a healthcare professional when the person is admitted for the procedure, if s/he has signed the form in advance). I have confirmed that s/he has no further questions and wishes the procedure to go ahead.

Signature .....Date .....

Name **(Print)** .....Job Title .....

Important notes: (tick if applicable)

☐ **See also advance directive/living will (eg Jehovah's Witness form)**

☐ **Person has withdrawn consent** .....Date.....

(ask person to sign/date here)

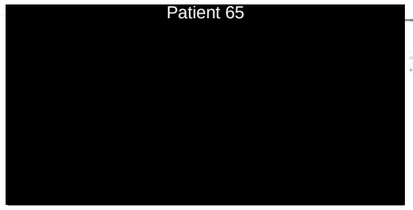
Southern Health and Social Care Trust

Location		
CAH	STH	DHH

Nursing Care Plan

For

Patients undergoing Minor Procedures Under Local Anaesthetic



Consultant ..... DR Curry .....

Surgeon .....

Date of Admission .....

Name of Staff Signing in Booklet (Block Capitals)	Signature
NIKKI CLARKE	[redacted]
SJ Tennyson	

Patient's Property

I have been advised to restrict to a minimum the amount of property, including cash, brought i hospital and to hand the Ward Sister/Nurse/Midwife in Charge as soon as possible any article wish to be kept in safe custody for which a receipt will be given.

I understand that I am responsible for **all** personal property brought into hospital.

I retain responsibility at all times for my personal properties, lost or damaged howsoever and not hold Craigavon Area Hospital Group Trust and its nominated officers liable in respect of, o damage to, personal property of any kind, in whatever way the loss or damage may occur.

Signed ..... Patient 65 ..... (Patient/Relative)

Please state reason where form not completed by patient (to be completed by nurse/midwife):

Witness ..... Personal Information redacted by the USI ..... (Nurse/Midwife)

Ward ..... DSU .....

Patients Hospital Number.....

Date ..... 5/5/17 .....

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

Patient 65 [redacted]

ADMISSION DETAILS

Date .....

Patient's Preferred Nam

Proposed Operation ....

Personal Information redacted by the USI [redacted]

.....

	Yes	No	Specify
Introduce Self to Patient	✓		
Orientated to Unit	✓		
Sequence of Events Explained	✓		
Encourage patient to express anxieties	✓		
Medications			
Allergies			
Comments/Evaluation			

Personal Information redacted by the USI [redacted]

Have you ever been notified that you are at risk of CJD or vCJD for public health purposes? **Yes ( ) No (✓)**

If yes to this question – CJD risk assessment initiated.

Personal Information redacted by the USI [redacted]

Hearing: Good ☑ Partial ☐ Deaf ☐ Hearing Aid ☐

Sight: Good ☑ Partial ☐ Blind ☐ Glasses ☐

Contact Lenses ☐

Personal Information redacted by the USI [redacted]

Temperature

Weight .....

Specific Anxie

.....

Designation

PATIENT IDENTIFICATION CHECKLIST

Approximate time of last food/flui

Personal Information redacted by the USI

Identification Bracelet in Situ
Dentures/Crowns
Loose Teeth
Prosthesis
Hair Accessories
Jewellery
Hospital Notes Available
Consent Form Completed
Operation Site Marked
Operation Site Prepared

DIGNITY

- Maintain Patient's Dignity
- Expose only as necessary

Comments/Evaluation .....

.....

MAINTAINING A SAFE ENVIRONMENT

- **Sterility** – Ensure this is maintained throughout surgery
- **Communication** – Explain procedures and stay with patient at all times throughout surgery

ANAESTHESIA

Personal Information redacted by the USI

SPECIMENS

Pathology ☐ Bacteriology ☐ Other ☐ Please specify .....

..... Recorded: Yes ☐ No ☐

Buffered Formaldehyde: Batch No ..... Expiry Date .....

Personal Information redacted by the USI

Designation

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

SWAB COUNT RECORD				
Ray-Tec Swabs (10 x 7.5cm)				
Swabs	5			
Issued by	Personal Information redacted by the USI			
Counted down by				
ATRAUMATIC NEEDLES				
Number Given				
Issued by				
BLADES				
Number Given				
Issued by				
HYPODERMIC NEEDLES				
Number Given				
Issued by				

Others .....

Diathermy

Diathermy used: Yes ☐ No ☒ Bi-Polar ☐ Monopolar ☐

- Prevent injury to patient when diathermy is used
- Apply diathermy pad appropriately
- Ensure patient's skin is not in contact with metal
- Avoid pooling of excess prep solution

Diathermy Pad Site
.....

Comments/Evaluation .....

Swabs, Needles, Instruments & Blades Correct		
Counted and Checked	Scrubbed Nurse	Runner
Pre-Operative		Personal Information redacted by the USI
Cavity Closure		
End of Procedure		

WOUND

Sutures: Type ..... Number .....

Dressing: Type .....

Signature of Nurse .....

Designation Personal Information redacted by the USI

OPERATION NOTES

Personal Information redacted by the USI

Patient 65

Procedure Performed.....

Findings & Procedure.....

Personal Information redacted by the USI

Personal Information redacted by the USI

Signature of Surgeon....

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

DISCHARGE ASSESSMENT			
	Yes	No	Comment
Light diet tolerated			
Advice given re aftercare	✓		
Wound			
District Nurse for Day 1			
Supplies given to Patient			
Sutures to be removed on			
Practice Nurse Referral			
Pain Score (0-3)			

GP Letter: Sent in Post ☐ Given to Patient ☐

Personal Information redacted by the USI

Discharge from Unit at

Patient's telephone nu

Comments .....

.....

.....

.....

Personal Information redacted by the USI

Signature of Nurse .....

Personal Information redacted by the USI

Received from DR Maria O'Kane on 29/06/22. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Quality Care - for you, with you

SHSCT Endoscopy Safety Checklist

Time Out (To be read Aloud)	Sign Out (To be Read aloud)
Before Commencement of Procedure (with Team Leader & Endoscopist- STOP all actions)	**Before Patient leaves Procedure Room**
Team introduction carried out Yes ☐ Patient's identity, procedure, consent & co-morbidities confirmed with Endoscopist? Yes ☐ Has all equipment used on the previous patient been removed from endoscopy room? Yes ☐	Specimen pots and pathology forms are correctly labelled (2 Nurses read specimen labels aloud, including patient name) Yes ☐ N/A ☐
Correct endoscope and all anticipated equipment needs available? Yes ☐ Has the correct endoscope been tracked to the correct patient? Yes ☐ Oxygen, suction, monitoring equipment & drugs available and checked? Yes ☐ Has Essential Imaging been reviewed All IRMER requirements met Yes ☐ N/A ☐	**Nurse Verbally Confirms with Endoscopist:** Any equipment problems to be addressed? Yes ☐ N/A ☐ Any complications during the procedure Yes ☐ N/A ☐ Recovery instructions documented in Endoscopy Care Pathway Yes ☐ N/A ☐ Follow up plans recorded in Endoscopy Report Yes ☐ N/A ☐ Recommencement of medication recorded on Unisoft report Yes ☐ N/A ☐
Confirmation of patient preference for sedation MA Yes ☐ Does the patient have a known allergy? Yes ☐ No ☑ Record of Last LMP Yes ☐ N/A ☐ Other hazard? E.g. MRSA/CJD Yes ☐ No ☐ Confirm any other risks e.g. Antiplatelets ☐ Anticoagulants ☐ Recent INR ☐ Is Antibiotic prophylaxis required? E.g. PEG insertion Yes ☐ No ☐	Patient 65 [redacted]
Emergency Bleeding Trolley available & fully stocked? Yes ☑ No ☐	Procedure: Personal Information redacted by the USI [redacted]
Confirm late start /reason for delay with medical staff and record on TMS? Yes ☐ N/A ☐	
SIGNATURE: Personal Information redacted by the USI [redacted]	
NAME:	

SHSCT Endoscopy Safety Checklist (January 2017 v0.8)

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

Personal Information redacted by the USI

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

MR48 GP Referral Letter

Referral to CAH Hospital

Date 27.08.13

Consultant

Department Urology

Please arrange: **Emergency admission** ☐ **Appointment for OPD:** *Urgent* ☐ *Routine* ☐

Health and Care Number [redacted]

Mr/Mrs/Miss/Other

Surname [redacted]

Forenames [redacted]

Address [redacted]

Postcode [redacted]

Date of Birth [redacted]

Home Tel No.

Mobile No.

Hospital No.

Reason for Referral/ History/ Examination/ Relevant Investigations:

[redacted]

Present Medication: See table ☐ See attached print-out ☐ None ☐ Unknown ☐

NAME, FORMULATION, DOSE AND FREQUENCY	NAME, FORMULATION, DOSE AND FREQUENCY
1. [redacted]	
2.	
3.	
4.	
5.	

Allergies / Drug Sensitivities

No Known Allergies ☐

DRUG (GENERIC) / ALLERGEN	TYPE OF REACTION

Other relevant information: [redacted]

Dr Anthony Glackin
GMC: 4362061

Routine ☑
Cons Clinic ☐
ICATS
GPwSI
LUTS
Prostate
Haematuria
Urodynamics
Stone Service
Andrology
Oncology
Female Urology

STAMP [redacted]

Doctors Signature [redacted] (Cypher No.) [redacted]

DOCTOR'S OR PRACTICE STAMP [redacted]

LPC 10/91/113

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

Thorndale Clinic

Patient 29

[redacted]

Personal Information redacted by the USI

[redacted]

Signature

Personal Information redacted by the USI

[redacted]

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

Patient 29 [redacted]

Date: 10-2-14

AL PROSTATE SYMPTOM SCORE (IPSS)

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
er the past month, how often ave you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	(5)
2. Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	(5)
3. Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	(5)
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	(5)
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	(5)
6. Over the past month, how often have you had to push or strain to begin urination?	(0)	1	2	3	4	5
7. Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None	1 time	2 times	3 times	4 times	5 or more times
	0	1	2	3	4	5
				Total IPSS Score =		35

o find your IPSS score, combine the sum of your answers for questions 1–7.
a score of 0–7 indicates **mild** symptoms, 8–19 indicates **moderate** symptoms, 20–35 indicates **severe** symptoms

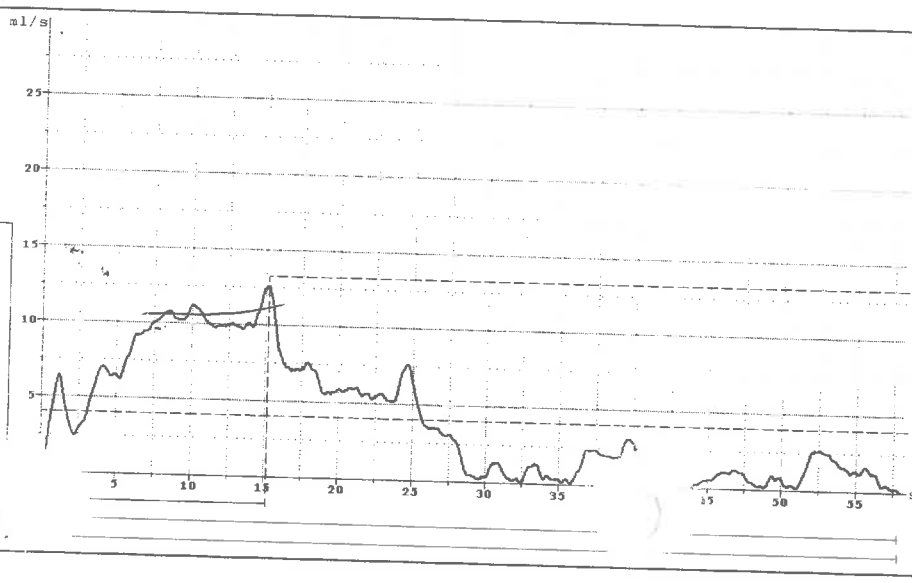
QUALITY OF LIFE DUE TO URINARY SYMPTOMS

	Delighted	Pleased	Mostly satisfied	Mixed about equally satisfied and dissatisfied	Mostly dissatisfied	Unhappy	Terrible
							√
8. If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	√ 6
			Quality of Life assessment index =				12

If you notice worsening in symptoms, please consult your GP

Mict
Fami
Firs
Age:
Date
Time
Com

Patient 29



SmartFlow

Time to maximum flow= 15.
Flow time= 56.
Voiding time= 57.8.

ALBYNMEDICAL
Smart Medical Group

LAB TUBE
387 801 ~~0508~~

Patient 29 [redacted]

1

Test date 10-02-14
Time
Operator [redacted]
Test number
Color Not Ent
Clarity Not Ent

GLU Negative
BIL Negative
KET Negative
SG 1.015
BLO Negative
pH 7.0
PRO Negative
URO 0.2 E.U./dL
NIT Negative
LEU Negative

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Patient 29

[redacted]

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT kg.		

LUTS CLINIC
10 FEB 2014
CAH

Personal Information redacted by the USI

[redacted]

LPC 03/08/021

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

UROLOGY DEPARTMENT
MR K SURESH
CONSULTANT UROLOGIST

Personal Information redacted by the USI

Dear DR Personal Information redacted by the USI

Re: Name: Patient 29
D.O.B: Personal Information redacted by the USI
Address: Personal Information redacted by the USI
Hospital No: Personal Information redacted by the USI **H&C No:** Personal Information redacted by the USI

Personal Information redacted by the USI

Thanking you.

Yours sincerely,

Mr K. Suresh MS, FRCS, FRCS (Urol)
Consultant Urologist

Date Dictated: 05/03/14	Date Typed: 07/03/14-NE

CRAIGAVON AREA HOSPITAL, 68 LURGAN ROAD, PORTADOWN, BT63 5QQ
Secretary: Mrs Noleen Elliott **Telephone:** Personal Information redacted by the USI
E-mail: Personal Information redacted by the USI

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

HSC Southern Health and Social Care Trust

Quality Care - for you, with you

SHSCT Endoscopy Safety Checklist

Team introduction	Before Commencement of Procedure (with Nurse & Endoscopist- STOP all actions)	Before Patient leaves Procedure Room (With Nurse & Endoscopist)
Team introduction carried out ☐		
Has Patient confirmed his/her identity, procedure and consent with Endoscopist? Yes ☐ No ☐ **Is Oxygen, suction, diathermy& drugs available and checked?** ☐ **Has Essential Imaging been reviewed** Yes ☐ No ☐ N/A ☐ **Are all IRMER requirements met** Yes ☐ No ☐ N/A ☐	**Do all team members know each other?** ☐ **Confirm late start /reason for delay with medical staff and record on TMS?** Y / N N/A **Confirm patients name & Procedure?** ☐ **Confirm any allergies?** ☐ **Confirm any other risks e.g. INR** ☐	**Nurse Verbally Confirms:** **The name of the procedure:** **Specimen labelling (read specimen labels aloud, including patient name) Yes** ☐ **No** ☐ **Any equipment problems to be addressed? Yes** ☐ **No** ☐
Does the patient have a known allergy? Yes ☐ No ☐ **Difficult airway or Aspiration risk?** Yes ☐ No ☐ **Equipment available if an event occurs?** ☐ **Risk of ≥ 500ml Blood Loss** Yes ☐ 2 IVs & Fluids planned No ☐	**ANTICIPATED EQUIPMENT NEEDS** **Biopsy Forceps** ☐ **Snares (Hot & Cold)** ☐ **Rothnet/Grasper** ☐ **Polyp trap** ☐ **Injector Needles** ☐ **Tattoo** ☐ **Clo-Test** ☐ **Resolution Clips** ☐ **APC / Gold Probe** ☐ **Specimen pots** ☐ **Diathermy pads** ☐ available **Is the 'Emergency Bleeding' Box available & fully stocked?** Yes ☐ No ☐	**What are the key concerns for Recovery and Management of this patient?** No concerns
Record of Last LMP Yes ☐ No ☐ **Other hazard? E.g. MRSA** Yes ☐ No ☐	**Is Antibiotic prophylaxis required? E.g. PEG insertion** Yes ☐ No ☐	
SIGNATURE: **NAME:**		

Patient 29

Personal Information redacted by the USI

HSS TRUST _____ | GP PRACTICE or other _____

Hospital Unit _____ | Primary Care Provider _____

FORM 1 - CONSENT FOR EXAMINATION, TREATMENT OR CARE

Personal details (or pre-printed label)

Surname/family name .....

First names .....

Date of Birth .....

❑ Male ❑ Female H+C No. (or other identifier) .....

Special requirements (language or other) .....

.....

[redacted] Patient 29

Statement of healthcare professional

Responsible healthcare professional ..... Job Title .....

Name of proposed procedure or course of treatment *(include side of body or site and brief explanation if medical term not clear)*

..... [redacted] Personal Information redacted by the USI .....

.....

I have explained the procedure. In particular, I have explained:

.....

.....

The intended benefits .....

.....

.....

Serious or frequently occurring risks [redacted] Personal Information redacted by the USI .....

.....

.....

Possible additional procedures which may become necessary during the procedure.

❑ Blood transfusion ❑ other procedure (please specify) .....

This procedure will involve: ❑ general and/or regional anaesthesia ❑ local anaesthesia ❑ sedation

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any samples of tissue that may be taken and any particular concerns of this individual.

❑ The following leaflet/tape has been provided .....

Signed..... [redacted] Personal Information redacted by the USI ..... Date .....

Name **(Print)** ..... Job Title .....

Contact details *(if patient wishes to discuss options later)* .....

Statement of interpreter (where appropriate)

I have interpreted the information above to the person giving consent to the best of my ability and in a way which I believe s/he can understand.

Signed ..... Date .....

Name (Print) .....

Copy accepted by person giving consent Yes / No (please circle)

Statement of person giving consent

Please read this form carefully. It your treatment has been planned in advance, you should already have your own copy which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed the form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in additional to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about possible additional procedures which may become necessary during my treatment I have listed below any procedures **which I do not wish to be carried out** without further discussion.

.....

.....

*** I agree** that healthcare students, who will be supervised by healthcare professionals, may observe or assist in my care. **You may remove this sentence without affecting your care.*

Signature ..... [redacted] Patient 29 ..... Date [redacted] Personal Information redacted by the USI .....

Name **(Print)** .....

A witness should sign below if the person is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes)

Signature ..... Date .....

Name **(Print)** .....

Confirmation of consent (to be completed by a healthcare professional when the person is admitted for the procedure, if s/he has signed the form in advance). I have confirmed that s/he has no further questions and wishes the procedure to go ahead.

Signature ..... Date .....

Name **(Print)** ..... Job Title .....

Important notes: (tick if applicable)

☐ **See also advance directive/living will (eg Jehovah's Witness form)**

☐ **Person has withdrawn consent** ..... Date .....

(ask person to sign/date here)

	Date	Clinical Notes
Age		Patient 29 [redacted] Personal Information redacted by the USI [redacted]
URINE Protein / Sugar / Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein / Sugar / Acetone		Personal Information redacted by the USI [redacted]
WEIGHT kg.		
→		
Age		
URINE Protein / Sugar / Acetone		
WEIGHT kg.		
→		Personal Information redacted by the USI [redacted]
Age		
URINE Protein / Sugar / Acetone		
WEIGHT kg.		

Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

URODYNAMIC CLINIC

Patient 29 [redacted]

Date: 9-1-15

Consultant: MR Suresh / MR O'Donoghue

Urodynamic Staff: M. Leonard
D. Campbell

Allergy: none known *Check allergy to latex* no

Urodynamics explained and consent obtained (Yes) / No

Personal Information redacted by the USI [redacted]

Bladder dairy functional capacity: 100 - 300 mls / diary not recorded □

LUTS: Present x storage

Frequency ½ - 1 hourly		Nocturia x 5	
Urgency	(Yes) / No	Urge incontinence	Yes / (No)
Hesitancy	Yes / (No)	Reduced stream	(Yes) / No
Interrupted flow	Yes / (No)	Straining	Yes / (No)
After dribble	(Yes) / No	Feeling incomplete emptying	Yes / (No)
Terminal dribbling	Yes / (No)	Pain	Yes / (No)
Double voiding	(Yes) / No	Haematuria	Yes / (No)
Dysuria	Yes / (No)	Urinary infection	Yes / (No)

Flow Study:

Volume voided:	204	mls
Qmax	14	mls/sec
Residual (Bladder scan):	279	mls

Filling /Voiding Cystometry:

Filling position: Standing ☑ Seated ☐ Lying ☐
Filling rate: 30 mls / min. Filling Fluid: 0.9% Sodiu

Siemens
Clinitek Status®

Serial Number:
1

Patient:

Multistix® 10 SG
Test date 09-01-
Time 1
Operator
Test number
Color Not Ent
Clarity Not Ent

GLU Negative
BIL Negative
KET Negative
SG 1.015
BLO Negative
pH 7.0
PRO Negative
URO 0.2 E.U./dL
NIT Negative
LEU Negative

UPP: mucp: cms/h20

Outcome of Urodynamic Studies:

[redacted]
Personal Information redacted by the USI

Signature/s:

Quality Care - for you

Patien
Name
D.O.B.
H&C N

Patient 29 [redacted]

is to be added to a Day-Case / Inpatient Waiting List

Date of Clinic / Decision to list	9/1/15
Consultant	[redacted]
Specialty	Urology

Please DO NOT list a Patient for surgery if further tests or assessments are needed

Diagnosis:	Personal Information redacted by the USI
Procedure:	
Estimated Duration of Surgery: 1 Hour	**Additional Comments / Instructions:**

Urgency *Please tick appropriate box*	
Red Flag	
Urgent	✓
Routine	
Planned	

Anaesthetic Type *Please tick appropriate box*	
General / Spinal	✓
Sedation	
Local	

IF NOT suitable for day of surgery admission – please state & give reason

Intended Management *Please tick appropriate box*	
Day Case	
Inpatient	✓

Patients should be listed as a day case if the intention is for no overnight stay following surgery. It does not matter which ward or unit they are admitted to.

Please note, that unless indicated below, for scheduling purposes the patient will be shared across the Trust.

Please detail if the patient is required to be admitted to:	
Specific Site Requirement	
Specific Unit Requirement	
Specific Consultant	

Is the Patient on any Anti-Coagulation Or Anti-Platelet Therapy? No ☐ Yes ☐

If yes, please indicate if patient is on any of the medications below and the action required:

- **Warfarin?** ☐ **PLEASE TURN OVER & indicate the bleeding risk of the procedure.**
- **Aspirin 300mg?** ☐ **Please advise whether the Patient should either:**
  a. Reduce to 75mg daily 7days prior to surgery ☐
  b. Continue to take as normal ☐
  c. Shoulder arthroscopy, thyroid, parotid or parathyroid surgery – stop all aspirin 7 days prior to surgery ☐
- **Clopidogrel** or **Prasugrel?** ☐ **Please advise:**
  a. Patient has had stenting within the past year thus Surgeon should contact Cardiologist to advise ☐
  b. Patient should discontinue 7days prior to surgery ☐
- **Dabigatran, Rivaroxaban or Apixaban?** ☐ **Please refer to Trust Guidance and SPC.**

Latex Allergy? No ☑ Yes ☐ **MRSA?** No ☑ Yes ☐

Diabetic? No ☐ Yes ☑ If yes, how is the diabetes controlled? Insulin ☐ Tablet ☐ Diet ☐

A decision to add a patient to the waiting list must be discussed and countersigned by the Consultant in charge.
If the Consultant is not available, then arrangements should be made to discuss decisions at a suitable point thereafter.

Doctor's Signature	Personal Information redacted by the USI
Countersigned (Consulta	

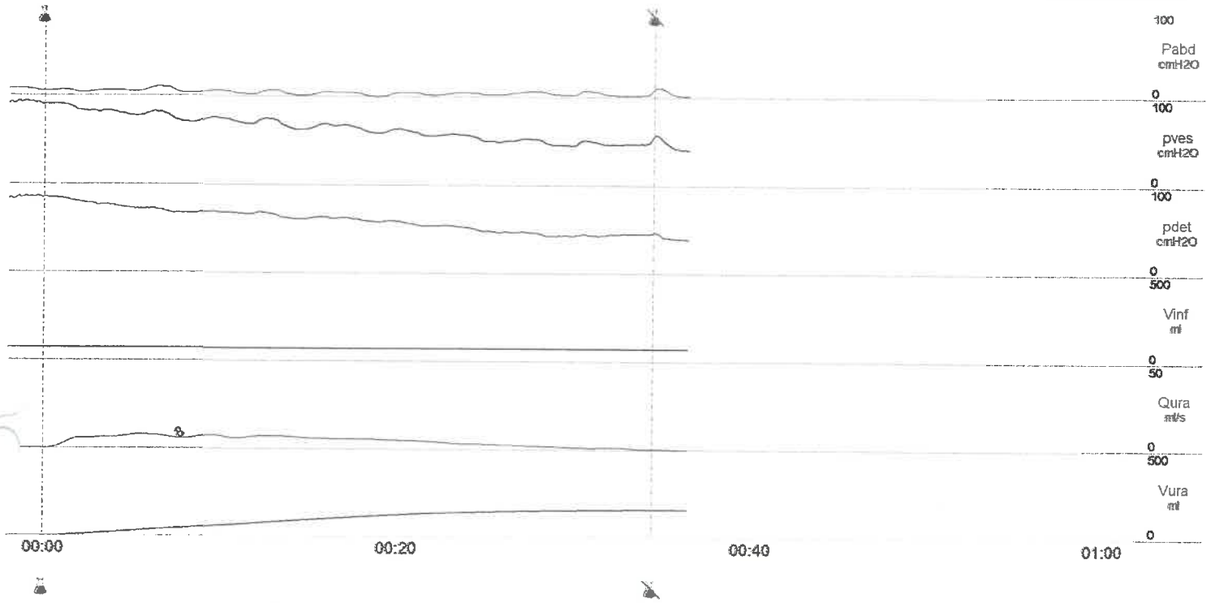
Received from Dr Maria O'Kane c

Craigavon Area Hospital

Craigavon
Urology
Clinician: MR O'DONOGHUE
Operator: M Leonard
Study Date: 09/01/2015 08:54

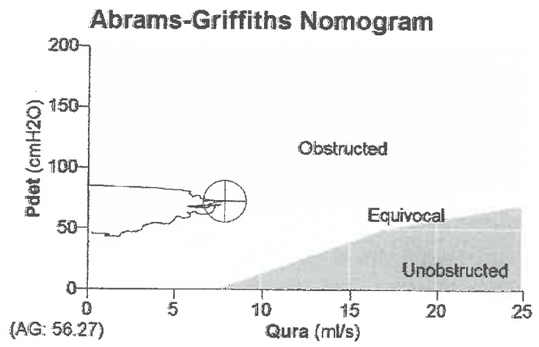
Southern Health and Social Care Trust

Patient 29
DOB: Personal Information redacted by the USI Age Personal Information redacted by the USI Years
Patient ID Personal Information redacted by the USI



Voiding Cystometry

Parameter	Value
Voiding time	34.4s
Flow time	32.2s
Time to maximum flow	5.5s
Opening time	s
Total voided volume	159ml
Residual volume	200ml
Volume at maximum flow	32ml
Maximum flow rate	8ml/s
Mean flow rate	5ml/s
Pdet minimum voiding pressure	43cmH2O
Pdet opening	85cmH2O
Pdet at maximum flow	72cmH2O
Pdet maximum	85cmH2O
Pdet closure	47cmH2O
Pves opening	91cmH2O
Pves at maximum flow	78cmH2O
Pves maximum	91cmH2O
Pves closure	56cmH2O
Static compliance	-4ml/cmH2O
Bladder Power at Maximum Flow	571ml/s*cmH2O
Passive Urethral Resistance Ratio	60.93
Passive Urethral Resistance Ratio Acceleration	-9.72
Total Bladder Capacity	359ml
Urethral Resistance Index	1.15



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Clinician: MR O'DONOGHUE
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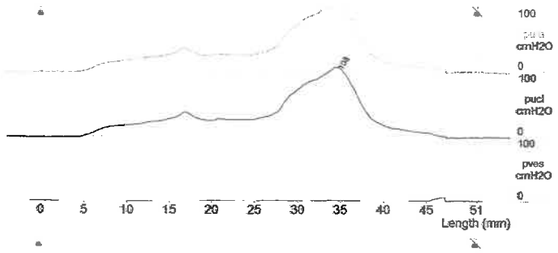
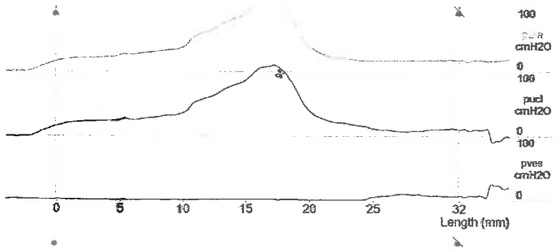


Parameter	Value
Total urethral profile length	51mm
Functional profile length	43mm
Closure zone length	30mm
Distance of maximum urethral closure pressure	70%
Mean urethral pressure	34cmH2O
Maximum urethral pressure	108cmH2O
Maximum urethral closure pressure	108cmH2O



Parameter	Value
Total urethral profile length	32mm
Functional profile length	24mm
Closure zone length	17mm
Distance of maximum urethral closure pressure	72%
Mean urethral pressure	47cmH2O
Maximum urethral pressure	112cmH2O
Maximum urethral closure pressure	95cmH2O

Bladder chart *Name:* [redacted] Patient 29 *Hospital No:*

	Day 1		Day 2		Day 3		Day 4	
	In	Out	In	Out	In	Out	In	Out
6am	[redacted] Personal Information redacted by the USI							
7am								
8am								
9am								
10am								
11am								
12md								
1pm								
2pm								
3pm								
4pm								
5pm								
6pm								
7pm								
8pm								
9pm								
10pm								
11pm								
12mn								
1am								
2am								
3am								
4am								
5am								

In = Type / amount of fluid that you drink that day (in mls)
Out = Amount of urine that you pass (in mls) / When you experience urine leakage.

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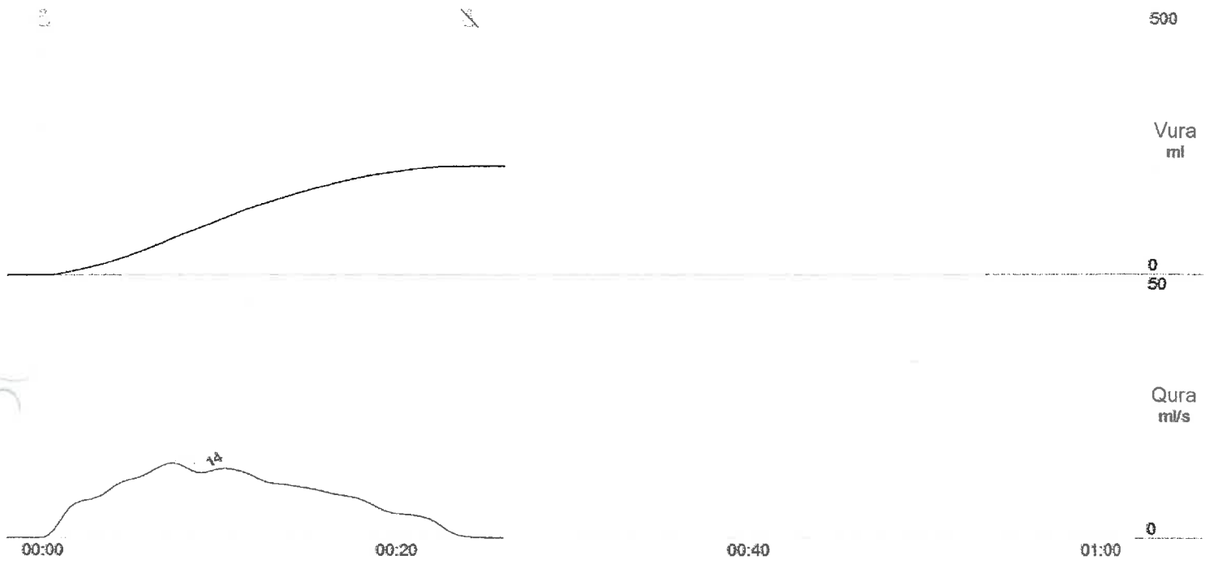
Patient ID Personal Information redacted by the USI



Mictiometry

Parameter	Value
Voiding time	24.8s
Flow time	24.8s
Time to maximum flow	7.3s
Maximum flow rate	14ml/s
Volume at maximum flow	70ml
Mean flow rate	8ml/s
Total voided volume	204ml
Residual volume	279ml

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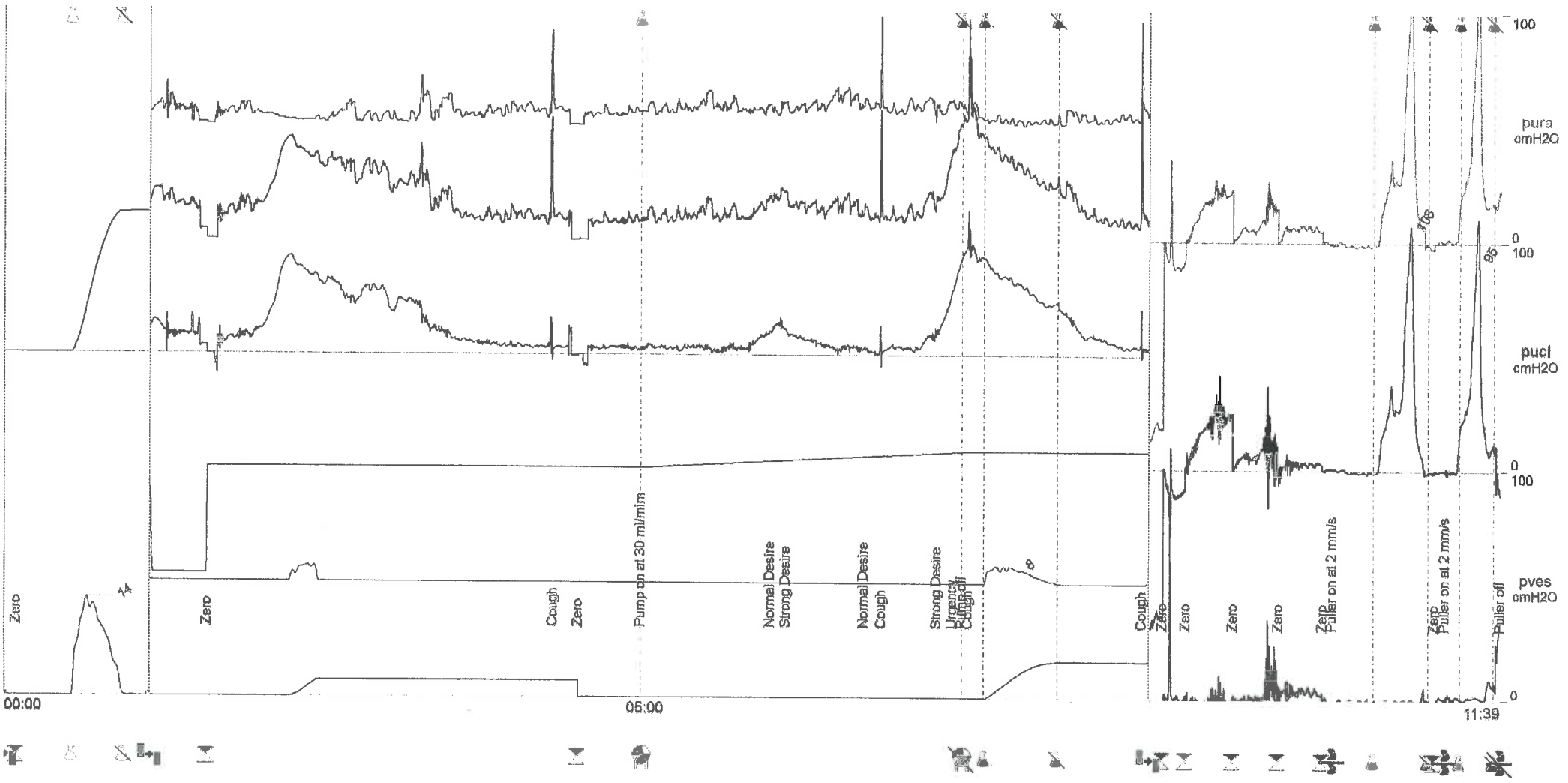
Patient ID



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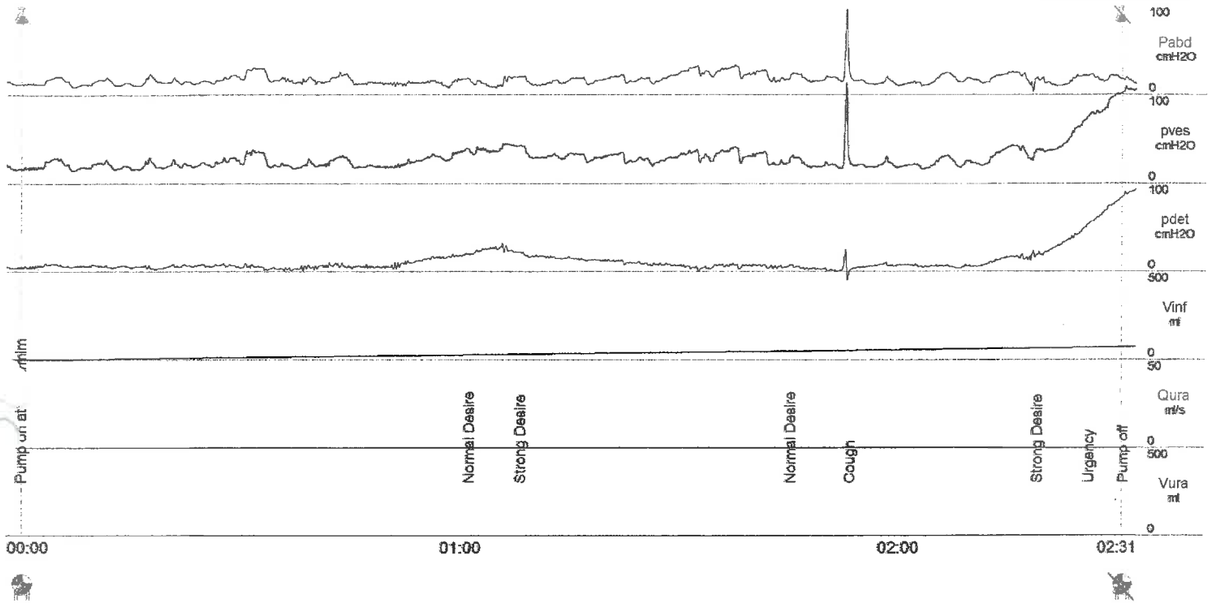
Patient 29
DOB: Personal Information redacted by the USI Age Person Years
Patient ID Personal Information redacted by the USI



Filling Cystometry

Parameter	Value
Cystometric capacity	73ml
Total bladder capacity	73ml
Static compliance	1ml/cmH2O
Pves at Start	16cmH2O
Pdet at normal desire	21cmH2O
Pdet at strong desire	22cmH2O
Pdet at urgency	54cmH2O
Vinf at normal desire	29ml
Vinf at strong desire	32ml
Vinf at urgency	70ml
Pdet at cystometric capacity	85cmH2O
Pves at cystometric capacity	103cmH2O
Pdet maximum during filling	85cmH2O
Pves maximum during filling	114cmH2O

No	Icon	Description	Time	Pabd cmH2O	pves cmH2O	pdet cmH2O	Vinf ml	Qura ml/s	Vura ml	Rate
6		Cough	04:17	25	27	2	0	0	72	
10		Normal Desire	05:59	18	39	21	29	0	0	
11		Strong Desire	06:06	21	43	22	32	0	0	
12		Normal Desire	06:43	21	29	8	50	0	0	
13		Cough	06:51	29	28	-1	54	0	0	
14		Strong Desire	07:17	19	39	20	67	0	0	
15		Urgency	07:24	22	76	54	70	0	0	
18		Cough	07:31	16	119	104	73	0	0	
21		Cough	08:52	68	69	1	73	0	160	

McCann, Frances

From: Cullen, Aidan
Sent: 16 February 2015 15:18
To: McCann, Frances
Subject: FW: Preoperative Assessment of your patient

From: Cullen, Aidan
Sent: 16 February 2015 14:24
To: ODonoghue, JohnP
Cc: Winter, Colin
Subject: Preoperative Assessment of your patient

Dear Mr O'Donoghue,

My name is Aidan Cullen and I am one of the anaesthetic consultants working in the Preoperative Assessment Clinic.

Re: Patient 29
DOB Personal Information redacted by the USI
HCN:

Personal Information redacted by the USI

I will contact her tomorrow.

Kind regards
Aidan

Tel Personal Information redacted by the USI

HSC Southern Health and Social Care Trust

Discharge Summary

Write clearly and use ballpoint pen

Ward:

_____ of _____ (if more than 1 sheet)

323026

Dear Doctor: _____

Your patient was admitted on: _____

to: CAH Hospital

under the care of: O'Donoghue

and is now being discharged to: Home

_____ on: 19/2/22

Write or use addressograph on all copies (must write if Controlled Drug)

Surname: Patient 29

First Names: [redacted]

Address: [redacted]

Hospital Numb[redacted]

Date of Birth: [redacted]

Personal Information redacted by the USI

Reason for admission: _____

Principal diagnosis on discharge: 1. _____

Other diagnoses / conditions: 2. _____ 3. _____

4. _____ 5. _____

Detailed discharge letter to follow Yes / No Awaiting test results Yes / No

Primary operation 1. _____ Date: _____

Other operations / procedures 2. _____ Date: _____ 3. _____ Date: _____

4. _____ Date: _____ 5. _____ Date: _____

Comments: _____

Arrangements for monitoring and review: Personal Information redacted by the USI

Copy for Patient File

Changes to medication during admission and reason **or** No change ✓ (please tick)

Allergies / Medicine Sensitivities

No known allergies ☐ (please tick) **or**

Medicines (generic) / allergen (type of reaction)

Discharge Prescription

Not suitable for 28 day supply of regular medication ☐ (please tick)

Medicine (use generic names, noting exceptions, **PRINT** clearly in capitals)	Dose (approved units)	Route	Frequency	Length of course / stop date	Complete for any medicine to be administered by Community Nursing: Date and time last dose given	Required from Hospital Pharmacy (✔)	Quantity dispensed

Personal Information redacted by the USI

Signature: [redacted]

LPC 01/08/04

Signature for Pharmacy: _____ Bleep Number: _____ Date: _____

Cc	Lab	Disp.
Final check	Date	

	Date	Clinical Notes
→		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		Personal Information redacted by the USI
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

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