

93-
sri SAI
HOSPITAL



SUPER
SPECIALITY

MORADABAD

Committed To Quality Health Care

Sri Sai Hospital, Moradabad
Department of Neurological Medicine
DISCHARGE SUMMARY

Blood Group : B Positive

Allergies :

Date of Admission: 7-Jun-17	Discharge 9-Jun-17	UHID No.: 85338/ 2017	IPD No.1217 /2017
Date of Procedure 1)	2)	WARD - PW	

PATIENT INFORMATION

Patient Name MR.OM PRAKASH SHARMA Age : 80 YRS Sex: M
S/o D/o W/o MR.ANOKHE LAL SHARMA
Address G J 104 RAILWAY COLONY
City : MORADABAD State: U.P. PIN : Contact Numbers :
Phone No or Mobile No. : 9760534528

Consultant Incharge : Dr Anand Singh MBBS,MD,DM
Department : Neurological Medicine
Other Consultant involved : Dr None
Department : None
Other Consultant involved : Dr None
Department : None

DIAGNOSIS: LEFT LOWER LIMB MONOPARESIS ACUTE ISCHAEMIC STROKE (THROMBOLYSIS DONE) FUC CAD (POST CABG) WITH OLD CVA WITH CERVICAL + LUMBER SPONDYLOSIS WITH PARKINSONISM.
Treatment/ Operation done: Conservative Treatment Given.

Presenting History: A 80 yrs male patient old FUC CAD Post CABG old CVA parkinsonism presented with C/O -Sudden onset left sided weakness since 2-3 hrs.

Examination : BP-160/90mmhg ,Pulse-86/ min,Temp- 98.6° F,SPO2- 96%, CNS- conscious, CVS-S1S2 -N.,Chest-B/L-Clear,P/A-Soft

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SRI SAI HOSPITAL
SUPER SPECIALITY
CARDIAC | TRAUMA | EMERGENCY
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CR No. 08311204/1907/19/02/1543

ISO 9001 : 2015 Certified

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Investigation:

DATE:-	07/06								
Hæmoglobin (gmy dl)	14.7								
TLC (Per cu mm)	4,990								
DLC (N,L,,E,B,M)	61.1/34.7/ 1.2/2.6								
GBP(mcv/mch/mchc)									
PCV									
Platelets (Lacs/ cu mm)									
ESR									
B. Sugar :Random	161.7								
:Fasting/ PP (mg/ dL)									
S.Sodium (meq/ L)	136.8								
S. Potassium (meq/ L)	4.24								
B. Urea (mg/ dL)									
S. Creatinine (mg/ dL)	1.06								
S.Calcium									
S. Uric Acid									
PO4									
ALP									
S. Bilirubin (mg/ dL)	0.57								
SGOT									
SGPT	17.3								
Prot.									
Alb.									
PT/INR	15.0 13.0 1.15 1.15 18.0 13.0 1.38								
BT									
CT									
HBSAg	Non-reactive								
HCV	Non-reactive								
HIV	Non-reactive								

X-Rays: NONE

USG : NONE

CT : 07-06-17 Head(Plain):-Mild bilateral periventricular ischaemic changes Diffuse small bilateral cerebral atrophy as described.

09-06-17 Head (Plain):-Finding appear more or less same.No evidence of other significant fresh findings.

MRI : NONE

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Other Investigations: APTT:-33.0/30.0(07/06)

Course in Hospital: A 80 yrs male patient old HUC CAD Post CABG old CVA parkinsonism presented with C/O -Sudden onset left sided weakness since 2-3 hrs. Patient was admitted in CCU & was thrombolysed with Inj. Actilyse 50mg i/v infusion. Patient improved gradually & now being discharged in a clinically stable state with follow up advice in OPD.

Patient status at Discharge: Patient conscious, afebrile, vitals normal stable, self voiding. Taking orally well.

Advice at Discharge:

CAP. PLEGERIN-A	150mg	HS.
TAB. AVAS	80mg	HS.
TAB. FOLIC ACID	5mg	OD.
TAB. SYNDOPA PLUS	125mg	TDS. (7AM, 11AM & 4PM)
CAP. REBEMAC-DSR		OD. (BBF)
TAB. GABAPIN-NT	400mg Halftab.	HS.
CALCEROL SACHET		TWICE A WEEK
CAP. NEUROKIND FORTE		OD.

Physiotherapy as advised.


Review After 5 Days In OPD Of Dr. Anand Singh

In case emergency please contact hospital emergency service(24hours)@ 0591-2479800.

Consultant - In - Charge

Resident - in - charge

(Dr Anand Singh MBBS, MD, DM
Department of Neurological Medicine


(Dr. Nirbhay Dwivedi)
Department of Neurological Medicine

NOTE: THIS IS AN IMPORTANT DOCUMENT, PLEASE KEEP THIS FOR FURTHER REFERENCE AND BRING ON YOUR NEXT VISIT

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Discharge Summary Report

Reg. No : MIM-A-048372	Patient Category : Cash
Patient Name : Mr Om prakash Sharma	IPD No. : 1652
Att Name : Sh. Anuj Kumar / Son	Admission Date : 30/11/17 2:42PM
Age & Sex : 80 Years / Male	Next Appointment : 04/12/2018
Address : H.P-18/1 GANGA NAGAR MERUT	Room No. : P-325
Phone : 9411666736	Bed No. : 325
Dr. Incharge : Dr. ARUN SHARMA / NEUROLOGY	Reference Dr. :
Discharge Date & Time : 04/12/2017 12:47PM	
Reason For Discharge : Shifted to Another Hospital	

Admission Diagnosis : LEFT HEMIPARESIS / DYSARTHRIA / ACUTE ISCHEMIC STROKE / FUC PARKINSON'S DISEASE.

Discharge Diagnosis : I63 -Cerebral infarction

Reason of Admission
Acute Stroke.

At Admission details
Presented with C/o- Left hemiparesis + difficulty in speaking.
Risk factors: Parkinson's disease.
Examination revealed PR 80 per minute, RR 24 per minute, BP 130/80 mm Hg, Temp. 98.2 0 F, O2 Saturation 98%. Nervous System: Left hemiparesis. CVS, Respiratory System and Abdomen are within normal limits.

Course During Hospitalization
Patient clinically evaluated, investigated and final diagnosis made as LEFT HEMIPARESIS / DYSARTHRIA / ACUTE ISCHEMIC STROKE / FUC PARKINSON'S DISEASE. During hospital stay patient gradually improved and discharged in satisfactory condition.
Treatment given: Conservative.
Positive Findings On Investigation: NCCT Head-Non specific small vessels disease. Hb-13.2 gm/dl. INR-1.41, B.Urea-50 mg/dl, Na+ 130 mEq/L.
Condition At Discharge: Presenting symptoms- regressing, PR 84per minute, RR 22per minute, BP 120/80mm Hg, Temp. 98.40 F, O2 Saturation 97%, Nervous System: Stable.

Discharge Instructions
Follow up advise: To come after 7 days in outdoor with prior appointment. Phone: Call / SMS - 9870838438, Any other query phone (0121) 2768833, 2767634, 9927005678. Clinical Hepline: 9837056769
Preventive instruction: Avoid risk factors as discussed.
Promotive instructions: Life style modifications as advised, Daily walk and exercises as advised, Dietary instructions: Normal diet

Review On: 4/12/2018

Dr ARUN SHARMA
MD, DM (Neurology)
Consultant Neurophysician
REG NO UP35792
CMO REG NO - MRT828

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Investigations

DATE	DESCRIPTION	PARAMETER	VALUE OBSERVED
30/11/2017	URINE ROUTINE	Quantity	10 ml
01/12/2017	SERUM HOMOCYSTEINE	Method	Enzymatic method
30/11/2017	ALKALINE PHOSPHATASE	RESULT	144
30/11/2017	BLOOD UREA	Result	50
30/11/2017	GLUCOSE RANDOM BLOOD	Blood Sugar (R)	149
01/12/2017	LIPID PROFILE	S. Cholesterol	165
30/11/2017	SERUM POTASSIUM	RESULT	3.5
30/11/2017	SERUM BILIRUBIN TOTAL & DIRECT	Total Bilirubin	0.8
30/11/2017	SERUM CALCIUM-TOTAL	Result	9.0
30/11/2017	SERUM CREATININE	Creatinine	1.0
30/11/2017	SERUM SODIUM	RESULT	130
30/11/2017	SGPT	Result	48
30/11/2017	ACTIVATED PARTIAL THROMBOPLASTINTIME (APTT)	Patient Plasma	35
30/11/2017	PROTHROMBIN TIME (PT)	Patient	22
30/11/2017	CBC/COMPLETE HAEMOGRAM	Haemoglobin	13.2
30/11/2017	ESR	ESR	40
30/11/2017	PERIPHERAL SMEAR EXAMINATION	RBC	NORMOCYTIC NORMOCHRO MIC BLOOD PICTURE
30/11/2017	BLEEDING TIME & CLOTTING TIME	BLEEDING TIME	3 min 10 sec

DATE	TEST
30/11/2017	CT HEAD WITHOUT CONTRAST
Result :	NCCT HEAD Serial contiguous 5mm sections were taken through posterior fossa. Study Reveals:- Ill defined hypodensities are seen at bilateral centrum semiovale & corona radiata Basal ganglia and thalami are normal. Sylvian fissures and sulci are normal. Ventricular system is normal. No midline shift is seen Cerebellum and brain stem are normal.
	IMPRESSION: CT FINDINGS ARE SUGGESTIVE OF: Non specific small vessel disease.

Signature Of Doctor
Dr ARUN SHARMA
 MD, DM (Neurology)
 Consultant Neurophysician
 REG NO UP 35 12

Signature Of Patient
 Mr Om prakash Sharma

Imp. Note: CMO REG NO - MRT826

This is an important document of your treatment. Please Keep it properly as hospital keeps record only for One Years. Original investigation reports has been handed over to the patient./ sent to the TPA.

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