

11/16/23, 1:02 PM



CHANDAN HOSPITAL

Address: Faizabad Road, Near Chinhat Flyover, Vijayant Khand, Gomti Nagar Lucknow-226010
 Email: care@chandanhospital.in Web: www.chandanhospital.in



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Patient Name : Mr.BABU LAL GAUTAM
Age/Sex : 62.4 YRS/Male
Doctor : Dr. Sumit Verma
Mobile No. : 9415848710
Panel : CASH

UHID : CH/23/034258
App. Date : 16-Nov-2023
App. Type : First Visit
Valid To. : 19-Nov-2023
BarCode :

Vital Signs :- N/A

History of Allergies : No known drug allergies

OD:One time a day
BD:Two times a day
TDS:Three Times a day
QID:Four times a day
HS:Night one time a day
A/D:One time alternate day
ODA/C :Morning one time a day
empty stomach
SOS:Emergency as and when needed

Provisional Diagnosis/Co morbidity : KNOWN CASE OF DM TYPE 2/CAD(DRUG DEFAULTER)
 CVA (MIDBRAIN INFARCT)

Sr	Name	Dose	Times	Dur.	Mea	Route	Qty	Remarks
1	CILACAR 5MG TAB~1x15~Cilnidipine 5 mg,	1	OD	1-Month			1	
2	ECOSPRIN AV 75/20 CAP~1x10~Aspirin 75 mg,Atorvastatin 20 mg,	1	OD	1-Month			1	1 WITH BREAKFAST AND 1/2 WITH BREAKFAST
3	ZORYL-M 1 TAB~1x15~Glimepiride 1 mg, Metformin 500 mg,			1-Month			1	
4	LEVEPSY 500MG TAB ~1x10~Levetiracetam 500 mg,	1	BD	1-Month			1	
5	RABLET D 20 CAP ~1x15~Rabeprazole 20 mg, Domperidone 30 mg,	1	OD	1-Month			1	
6	CREMAFFIN PLUS SF SYP 225ML~1X1~Liquid Paraffin 1.25 ml, Milk of Magnesia 3.75 ml, Sodium picosulfate	10	ML	HS			1	
7	BETONIN AST SUGAR FREE 200ML ~1x1~Vit B6 HCl/ Pyridoxine HCl 1.5 mg, Nicotinamide 45 mg, Cyanocobalam	1	TSF	BD	1-Month		1	

Doctor Advice/Prescription : REVIEW AFTER 1 MONTH

Dr. Sumit Verma
 M.D. (Medicine), D.M. (Neurology), Reg No.78343



EMERGENCY NO.
 0522-6666666

13 Sep 2023



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Since 1991

Patient NAME	: Mr. BABU LAL GAUTAM	UHID	: CH/23/034258
Age/Sex	: 62.1 YRS Sex : Male	IPDNo	: 99075
Mobile No.	: 9415848710	Admission Date	: 24-Aug-2023 9:10 AM
Address	: 647 b/d-70 jankipuram garden jankipuram lucknow,,INDIA	Discharge Date	: 29-Aug-2023 4:08 PM
Doctor	: Dr. Rajendra Kumar Pandey	Ward	: SPR/Second Floor/229/2

DISCHARGE SUMMARY

Diagnosis :

K/C/O- T2DM / CAD (DRUG DEFAULTER)
SUDDEN ONSET LEFT HEMIPARESIS WITH RIGHT 3rd NERVE PALSY CAUSE ?
MID BRAIN INFARCT (WEBER SYNDROME)

Reason for Admission :

C/O- VERTIGO X AFTERNOON OF 23/8/23
SUDDEN ONSET OF LEFT SIDED BODY WEAKNESS X 7 AM 24/8/23
SLURRING OF SPEECH
DEVIATION OF ANGLE OF MOUTH LEFT SIDE
BLURRING OF VISION

History Of Present Illness :

ACCORDING TO INFORMANT PATIENT WAS WELL BEFORE YESTERDAY AFTERNOON WHEN HE HAD VERTIGO , ALONG WITH GENERALISED WEAKNESS . ON TODAY 7 AM IN THE MORNING HE HAD LEFT SIDED WEAKNESS ALONG WITH SLURRING SPEECH AND DEVIATION OF ANGLE OF MOUTH. > PATIENT WAS SHIFTED TO IKON HOSPITAL FOR FURTHER MANAGEMENT > NCCT HEAD DONE , ACCORDING TO INFORMANT NO TREATMENT RECIEVED AND PATIENT BROUGHT TO CHL FOR FURTHER MANAGEMENT .

History of Past Illness :

K/C/O- T2DM X 2014
CAD (POST PCI TO RIGHT RCA IN 2013)
H/O- COLECYSTECTOMY X 2020

Examination :

VITALS AT TIME OF ADMISSION:-

B.P- 160/77 MMHG
H/R- 72 / MIN

CNS- GCS-E4V5M6
CVS- S1&S2 HEARD



Prepared By : DR.ARADHITA AGARWAL

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HR- 20 / MIN
 TEMP- 97.9 F
 SPO2- 97% ON RA
 RBS- 248 MG/DL

R/S- B/L AIR ENTRY PRESENT
 P/A- SOFT & NON TENDER

Significant Findings/Course of stay :

ON 24/08/2023, PATIENT WAS BROUGHT IN EMERGENCY WITH THE ABOVE MENTIONED COMPLAINTS. AFTER HISTORY & EXAMINATION > RELEVANT INVESTIGATIONS WERE SENT > PATIENT WAS MANAGED & SHIFTED TO HDU FOR FURTHER MANAGEMENT. PATIENT WAS BEING MANAGED IN HDU ON IV ANTIBIOTICS, AND OTHER SUPPORTIVE MEASURES. ON 25/08/2023 , CARDIOLOGIST REFERENCE DONE FOR ECHO AND ADVISE FOLLOWED . PATIENT SHIFTED TO WARD FOR FURTHER MANAGEMENT. NOW PATIENT CLINICALLY BETTER CONCIIOUS, FOLLOWING VERBAL COMMAND HAVING RIGHT PTOSIS + MILD LEFT HEMIPARESIS WITH GCS-E4V5M6. PATIENT IS NOW BEING DISCHARGE ON ORAL MEDICATIONS ADVISED.

Investigations :

ATTACHED

Treatment Given :

INJ MONOCEF 1 GM BD
 INJ LEVERA 500 MG BD
 INJ PAN 40 MG IV OD
 INJ EMESET 4 MG IV OD
 INJ. OPTINEURON 1amp. IV BD
 TAB. ECOSPRIN GOLD 20MG HS
 TAB CILACAR 5 MG OD
 TAB SETBRAIN 60 MG IV BD
 TAB. NUREWIRE 1TAB. BD
 TAB. FOLVITE 5MG OD
 TAB. QUTAN 25MG 1/2TAB. IIS
 SYP. CREMAFFIN PLUS 15ML. HS
 INJ. H. INSULIN-R S/C A/C TO S/S



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Condition At Discharge :
SATISFACTORY

Treatment Advice on Discharge :

TAB CILACAR 5 MG 1 TAB OD
CAP ECOSPRIN GOLD 20 MG HS *Elosprin-A V*
TAB SETBRAIN 60 MG BD
TAB ZORYL M1 BD (1 TAB IN MORNING AND HALF TAB AT NIGHT)
TAB QUTAN 25 MG HALF TAB HS
TAB LEVEPSY 500 MG BD
CAP RABLET D 20 MG OD
SYP CREMAFFIN PLUS (SF) 10 ML HS
EYE + LIMB PHYSIOTHERAPY AS ADVISED

OD-ONCE DAILY
BD-TWICE DAILY
TDS-THRICE DAILY
QID-FOUR TIMES A DAY
HS-AT NIGHT
SOS-AS NEEDED

Advice On Discharge :

REVIEW AFTER 7 DAYS IN NEUROLOGY OPD.

Follow-up Instructions :

FOLLOW UP IN CASE OF EMERGENCY LIKE HEADACHE, VOMITING, LOSS OF CONCIUSNESS, BLURRING OF VISION, ABNORMAL BODY MOVEMENT, UPROLLING OF EYE, FROTHING FROM MOUTH, SLURRING OF SPEECH, ALTERED SENSORIUM, ANXIETY, WEAKNESS IN LIMB OR AS EXPLAINED PLEASE VISIT CHANDAN HOSPITAL OR CALL ON 0522-6666 666.



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Qualification & Registration No :

Dr. R. K PANDEY

DM NEUROLOGY
CHAIRPERSON
NEUROMEDICINE

Dr. SUMIT VERMA

DM NEUROLOGY
VICE CHAIRPERSON
NEUROMEDICINE

Dr. Anurupa

*** End Of Report ***



H-2021-0764



(QA/CAHS/CC/2021/0003)

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