Recovery after ischaemic stroke: discharge

Assume that today's date is 6 November 2026. Mrs Ogbuehi is being discharged home today in the United Kingdom. This is original independent practice material; patient details, findings and individual treating-team arrangements are fictional case facts, not general clinical recommendations. Allow 45 minutes: 5 minutes for reading and 40 minutes for writing. You are the doctor discharging Mrs Chinelo Ogbuehi from the stroke unit. Using the case notes, write to her regular general practitioner, Dr Ozioma Okeke, explaining her residual functional needs and requesting ongoing community review and secondary prevention. Clarify which investigations and treatment decisions remain with the stroke team. Address the letter to Dr Ozioma Okeke, General Practitioner, 18 High Street, SW19 4AB, United Kingdom. In your answer: expand the relevant notes into complete sentences; do not use note form; use letter format. The body of the letter should be approximately 180–200 words.

Choose one box per line: I = Include / C = Compress / O = Omit. Answers and reasons are on the webpage (scan QR).

	I	C	O
Patient details			
1. Name: Mrs Chinelo Ogbuehi	☐	☐	☐
2. DOB: 14/03/1957 (69 yrs)	☐	☐	☐
3. Admitted 21/10/26; discharge home 06/11/26	☐	☐	☐
4. Regular GP: Dr Ozioma Okeke; established history known	☐	☐	☐
Social background			
5. Lives with husband; daughter nearby	☐	☐	☐
6. Daughter staying initially; agrees to supervise medicines and assist dressing	☐	☐	☐
7. Previously independent; retired librarian; enjoys crosswords	☐	☐	☐
8. Complained about ward meals	☐	☐	☐
Medical history			
9. Hypertension; amlodipine unchanged	☐	☐	☐
10. Hypercholesterolaemia; previously declined statin	☐	☐	☐
11. Appendicectomy 1989	☐	☐	☐
12. No known drug allergies	☐	☐	☐
Admission and investigations			
13. 21/10: L hemispheric ischaemic stroke; R weakness, expressive dysphasia	☐	☐	☐
14. MRI: L middle cerebral artery territory infarct	☐	☐	☐
15. Initial CT: no haemorrhage	☐	☐	☐
16. CT angiography: no large-vessel occlusion	☐	☐	☐
17. Carotid imaging: mild bilateral plaque; no significant stenosis	☐	☐	☐
18. Inpatient telemetry: no AF detected; cause remains uncertain	☐	☐	☐
19. Echocardiogram: no intracardiac thrombus	☐	☐	☐
Treatment and progress			
20. Medically stable; no recurrent neurological symptoms during rehabilitation	☐	☐	☐
21. Residual R hand weakness, mild expressive dysphasia; comprehension preserved	☐	☐	☐
22. Transfers independently; stick indoors, supervision outdoors; help dressing/medicines	☐	☐	☐
23. Swallow assessment: ordinary diet, thin fluids	☐	☐	☐
24. OT home assessment completed; recommended equipment installed before discharge	☐	☐	☐
25. Team plan: long-term clopidogrel + atorvastatin commenced; acute aspirin ceased; complete, reconciled discharge medication list incl. individual doses, routes, frequencies, durations and changes enclosed with letter to GP	☐	☐	☐
26. Discharge medicines supplied; daughter practised supervised administration	☐	☐	☐
27. Patient/husband taught FAST: call 999 for sudden new stroke symptoms, even if resolving	☐	☐	☐
Discharge plan			
28. GP review requested 13/11: BP, adherence, tolerability; ongoing prevention prescribing per enclosed medication list/risk-factor management	☐	☐	☐
29. Stroke team to arrange ambulatory ECG, review result and decide treatment changes; clinic 04/12	☐	☐	☐
30. Home rehabilitation accepted: physiotherapy, OT, speech therapy; first visit 09/11	☐	☐	☐
31. Tearful about dependence; no suicidal thoughts; GP to review mood	☐	☐	☐
32. Does not drive	☐	☐	☐

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