Republic of Rwanda

Ministry of Health

Rwanda Biomedical Centre

Healthy People, Wealthy Nation

Registre des Consultations Externes (Register for out Patient Department)

Formation Sanitaire : _____

Date de début du registre: .....

Date de fin du registre: .....

Numéro du registre: .....

VERSION 2022

GUIDANCE ON HOW TO COMPLETE THE OUT-PATIENT REGISTER

Each row is a single consultation visit. Unlike for chronic care registers, the Outpatient register is an acute (or one-off) care registers. That means that a patient can be entered more than once in the same register. Every patient who visits the health facility has to get registered prior to getting any consultation, treatment or investigations done.

1. Purpose of the Out-Patient register and how it will be used

The Outpatient register serves the purpose of tracing patient's visits history in order to guide clinical officers during each consultation. The case-based information collected in the register can play an important role in tracing individuals in case of an outbreak. The centralized summary of case-information within each register facilitates acts as a useful monitoring and evaluation tool.

L'objet du registre des patients en consultation externe et comment il sera utilisé
Le registre des patients en consultation externe permet de suive l'historique des consultations pour un patient afin d'orienter le personnel soignant au cours de chaque consultation. Les informations collectées cas par cas dans le registre peuvent jouer un rôle important de suivi individuel au cas où il y a une épidémie. La récapitulation centralisée des informations sur chaque cas contenu dans le registre sert d'outil de suivi et évaluation utile.

2. Where to find the information

For every visit to the health facility, the first point of information collection is at the reception where the patient is required to provide demographic information such as name, age, sex and address, previous visits to the facility and health insurance details, department or unit and consultant to be visited. During consultation with the clinical staff, information on history, diagnosis and prescribed medication and investigation might be collected on individual patient file (depending on the type of facility) and should be transferred to the outpatient register for cases that are not admitted to the health facility.

Où trouver l'information
Pour chaque visite à la formation sanitaire, le premier point de collecte d'information est à la réception où le patient est demandé de fournir des informations démographiques telles que le nom, l'age, le sexe et l'adresse, les visites antérieures à la formation sanitaire et les coordonnées d'assurance santé, l'unité à visiter et le médecin qui le consulte. Au cours de la consultation par le personnel soignant, les informations sur l'historique, le diagnostic ainsi que les médicaments et examens prescris peuvent être collectées dans le dossier de chaque patient individuel (selon le type de formation sanitaire) et devraient être transférées dans le registre des patients en consultation externe pour les cas qui ne sont pas hospitalisés à la formation sanitaire.

3. How to record the information

Comment enregistrer les informations

Please note that the columns in the register are referred to as column 1, column 2, etc. even though they are not actually numbered on the register.

3.1. N° mensuel [Month serial number]: Record the patient's month serial number for the month. At the beginning of the month, restart numbering at 1. Then assign each patient visiting that month the next serial number. This is a quick way of tracking how many patients consulted each month.

3.2. N° journalier [Day serial number]: Record the patient's day serial number for the day. At the beginning of the day, re-start numbering at 1. Then assign each patient visiting that day the next serial number. This is a quick way of tracking how many patients consulted each day.

3.3. Date de visite [Date of visit]: Record the date of the visit in format dd/mm/yyyy

3.4. N° Dossier du malade [Patient file number]: Record the patient's file number from the patient's dossier.

3.5. Nom et Prénom [Name in Full]: Record full name of the patient with the family name written in the upper space and given name in lower space (e.g KAGUBARE / Marie).

3.6. Addresse: chef de fam [family head]: record the name of the family head. The family head is an individual in the household who provides support and maintenance to household members either related to him or her by blood, marriage or through adoption.

3.7. Addresse: Secteur [sector]: record the sector in which the patient currently resides

3.8. Addresse: Cellule [cell]: record the cell in which the patient currently resides

3.9. Addresse: Umudugudu [village]: record the village in which the patient currently resides

3.10. Transferé (e) par les ASC [refered by CHW]: record yes if the patient was referred by CHW.

3.11. Provenance [catchment area]: Record "Z" if patient currently resides within the health facility catchment area, "HZ" if the patient currently resides outside the health facility catchment but within the district where the facility is located and "HD" if patient currently resides outside the district where the facility is located.

3.12. Nouveaux Cas / Ancien Cas [New case / Old case]: Classify as "NC" for new case or "AC" for old case. A new case means a new episode of illness diagnosed in a patient during a consultation. To facilitate the new case we define a maximum period betwee ntwo episodes of illness, making any new episodes occurring after this period a new case. An average period of one month is used in Rwanda for all diseases (except for chronic diseases whose therapeutic management is long and which have their own definitions). An old case is a patient registered as new case for an episode of disease already diagnosed and treated and returned to the consultation within a period of 1 month because she or he is not cured. This definition does not include chronic diseases such as leprosy, tuberculosis, AIDS, diabetes .., requiring long therapeutic care.

3.13. Statut d'enregistrement: Record 1. if the client was referred, 2. if "patient habituel", 3. if "contre référé"

3.14. Age: Record the patient completed age in months for infants less than 1 year) and in years if patient is 1 year or older in the appropriate age category column corresponding the exact age of the patient.

3.15. Sexe [sex]: record the gender of the patient as "M" for male or "F" for female.

3.16. Poids [weight]: record the current weight of the patient in kilograms

3.17. Taille (Height / cm): Record the height in centimeter

3.18. Plaintes/ symptomes et signes cliniques [Presentation/clinical signs and symptoms]: record annotated list of most significant symptoms (from history) and signs (from examination).

3.19. Depistage de la Tuberculose/TB screening: Y=presumptive TB is people with cough for 2weeks. This can be accompanied but not necessarily, by fever, night sweats, loss of appetite, weight loss (poor weight gain in children), sputum production, chest pain, fatigue, hemoptysis. NB: systematic screening is recommended for children<15 years and people 55years above, PLHIV,TB contact, prisoners, miners. N=not presumptive is person with sign and symptom of presumptive TB.

3.20. Dépistage HIV: This is HIV testing after specific counseling

3.21. Dépistage IST [STI Screening]: For adult patients, indicate the STI screening outcome as P=positif; N=negative; PF=pas fait; or PA=pas applicable

3.22. Dépistage Nutrition (Nutrition screening): Identify patient who are already malnourished or at risk of becoming malnourished.

3.23. Dépistage NCDs [NCDs Screening]: Dépistage NCDs [NCDs Screening]: For adult 35 years old and above (Systematic blood pressure at every visit and blood sugar measurement once a year). For women, ask for signs and symptoms for Breast Cancer (1. New lump in the breast or underarm (armpit), 2. Thickening or swelling of part of the breast, 3. Nipple retraction, 4. Abnormal nipple discharge, 5. Breast skin readness, 6. Painful Swelling of the breast) and Cervical Cancer (1. Abnormal vaginal bleeding, 2. Bleeding after sexual intercourse, 3. Abnormal vaginal discharge, 4. Bleeding after menopause, 5. Permanent pelvic pain) Indicate the NCD screening outcome as P=Positif (Preciser NCD); N=Negatif; PF=Pas fait; or PA=Pas applicable. Remember to refer suspected or confirmed cases to the NCD Clinic for further investigations and management.

3.24. Fever or history of fever within 48hours: Record yes, if the patient has fever based on temperature taken or if the patient has history of fever within 48hours.

3.25. Examens Complémentaires/ Laboratoire [Investigations / laboratory examinations]: Enter any investigations or laboratory examinations conducted during consultation in this column.

3.26. Resultats d'examens [Examination results]: Record annotated list of the results of investigations or laboratory examinations.

3.27. Resultants ex parasitologique (TDR ou GE): Record in upper row the type of test and record result in lower row.

3.28. Age gestationnel si femme enceinte [Gestation age if pregnant]: record the gestational age in weeks. Gestational age is the time measured in weeks from the day of the mother's (in this case pregnant woman's) last menstruation to the current date. Obtain the woman's last menstruation date and subtract it from the current date of consultation visit to calculate the gestation age of the current pregnancy.

3.29. Diagnostic Principal [Main Diagnosis]: Enter the main diagnosis. Case definition criteria should be used for reporting purposes only, and not to guide clinical management or treatment. If more than one diagnosis is made, use a separate row to record each

3.30. Classification Malade [Disease Code]: Record the disease code of the principal diagnosis from the MOH list of disease codes

3.31. Diagnostic Secondaires [Secondary Diagnosis]: Enter any secondary diagnosis. See instructions above

3.32. Traitement/ Mesures prises [Treatment / Action taken]: record annotated treatment given. Only include treatment or action relevant to the diagnosis. For prescribed drugs, enter name, dose and duration.

3.33. Résultats [Outcome]: Record outcome as "A" for improved, "H" for hospitalized, "R" for referred, "D" for died and "C" for counter-referral.

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N° mensuel *Month serial number*	N° journalier *Day serial number*	Date de visite *Date of visit*	N° Dossier du malade *Patient file number*	Nom et Prénom Name in Full **En haut: Nom** *Upper space Surname* **En bas: Prenom/** *Lower space given name*	Addresse			Transféré (e) par les ASC refered by CHW	Provenance/*Catchment area* (Z, HZ,HD)	Nouveaux Cas (NC) Ancien Cas (AC)	Statut d'enregistrement 1. Référé(e) 2. Patient habituel 3. Contre référé	AGE												Sexe *Sex* (M/F)	Poids *Weight* (Kg)	Taille (Height) **(cm)**	Plaintes/ symptomes et signes cliniques *Presentation/clinical signs and symptoms*
					Chef de Famille (Nom et prénom) *Family head (full names)*	**En haut: District** *upper row: District* **En bas: Secteur** *lower row: Sector*	**En haut: Cellule** *upper row: Cell* **En bas: Umudugudu** *lower row: village*					0-11 mois	1 - 4 ans	5 - 9 ans	10 - 14 ans	15 - 19 ans	20 - 24 ans	25 - 29 ans	30 - 34 ans	35 - 39 ans	40 - 49 ans	50 - 70 ans	70 + ans				

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Dépistage TB *TB Screening* **Y** = Presumptive TB **N** = not presumptive	**Dépistage VIH /HIV** *Screening* **P**= Positif **N**= Negatif **PF**= Pas fait	**Dépistage IST** *STI Screening* **P=**positif (préciser IST) **N=** negatif **PF=** pas fait **PA**= pas applicable	**Dépistage Nutrition** *Nutrition Screening* **P=**positif **N=**negatif **PF=**pas fait **PA**=pas applicable	**Depistage NCDs/ Screening NCDs** **P=**Positif (préciser NCD) **N=**Negatif **PF=**Pas fait **PA**=Pas applicable	**History of fever within 48hours** **O**= Oui **N**= Non	**T°** Tempera-ture	**Examens Complémentaires/ Laboratoire** *Investigations / laboratory examinations*	**Resultats d'examens** *Examination results*	**Resultat Ex Parasitologique (TDR ou GE)** **P= Positif** **N=Negatif** **NA=Non Applicable**	**Etat Gravidique** *Pregnancy status* **1. Enceinte** **2. Non Enceinte** **3. Non applic**	**Diagnostic**				**Traitement/ Mesures prises** *Treatment / Action taken*	**Résultats** *Outcome* **[A,H,R,C,D] ****	**Type d'assurance maladies (préciser)** *Type of health insurance* **Si/if Mutuelle** Numero en bas / *Number below*
											Principal *Main*	**ICD-11** (CODE)	**Secondaires** Secondary	**ICD-11** (CODE)			
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‡ Motif de sortie [reason for exit]: 1. Sortie authorisée [authorized discharge] ; **2.** Sortie non authorisée [unauthorized discharge]; **3.** Décès (<24heures) [death <24 hours]
4. Décès (>24heures) [death >24 hours]; **5.** Référé [referral]