Republic of Rwanda

Ministry of Health

Rwanda Biomedical Centre

Registre des Patients Hospitalisés (Hospitalization/ Admission Register)

Formation Sanitaire: ________________________________

Date de début du registre: ……………………………………………………………………………

Date de fin du registre: ……………………………………………………………………………

Numéro du registre: ……………………………………………………………………………

VERSION 2022

Guidance on how to complete the Hospitalization (In-Patient) Register

Each row is a single admission. Like the outpatient register, a patient can be entered more than once in the same register depending on the different admissions. Patient registration begins when the patient is allotted a bed in the ward.

1. Purpose of the In-Patient (Hospitalization) register and how it will be used

The In-patient (hospitalization) register serves the purpose of tracing patient's consultation visits history, investigations, procedures and medication 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.

2. Where to find the information

For every admission to the health facility, the first point of information collection is at the ward where the patient is required to provide demographic information such as name, age, sex and address, health insurance details, and patient's clinical data. During the length of stay in the hospital, information on investigations, procedures and medication is collected and should be transferred to the inpatient register.

3. How to record the information

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° d'Hospitalization [Hospital serial number]: Record the patient's hospital serial number for the month. At the beginning of the month, restart numbering at 1. Then assign each patient admitted that month the next serial number. This is a quick way of tracking how many patients are admitted each month.

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

3.3. 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).

3.4. 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.

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

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

3.7. Type d'assurance maladies [Type of health insurance]: record the type of health insurance held by the patient.

3.8. 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.

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

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

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

3.12. 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.

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

3.14. 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.

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

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

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

3.18. 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.

3.19. 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.

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

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

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

3.23. 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 diag- nosis is made, use a separate row to record each

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

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

3.26. 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.

3.27. Références Internes [Internal referrals]: Indicate if there are any transfer or referral to another care unit with the hospital and indicate the unit and service (e.g. PIT)

3.28. Entrée [Date of admission]: Record the date when the patient was admitted in the hospital. This is the date when the patient was allotted a bed.

3.29. Sortie [Date of exit]: record the date of exit for the patient from the hospital

3.30. N° de jours d'hospitalization [Length of stay (days)]: Record the number of days between admission and exit in this column

3.31. Causes de sortie [Reason for exit]: Record the reason for exit using the options provided in legend at the bottom of register page. Record as 1= authorized discharge, 2= unauthorized discharge, 3= death <24 hours, 4= death >24 hours and 5= referral.Décès (<24heures) [death <24 hours]

1. Décès (>24heures) [death >24 hours]
2. Référé [referral]

REGISTRE DES PATIENTS HOSPITALISES

N° de serie mensuelle *Monthly serial number*	**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** *Address*			**Provenance (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*	**Symptomes et signes cliniques** *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**	**1-4ans**	**5-9ans**	**10-14ans**	**15-19 ans**	**20-24 ans**	**25-29 ans**	**30-34 ans**	**35-39 ans**	**40-49 ans**	**50-70 ans**	**70+ans**			

REGISTRE DES PATIENTS HOSPITALISES

<table>
<tr><th rowspan="2">**Depistage TB/ TB** *screening* **Y:** *pre-sumptive TB* **N:** *not presump-tiveive*</th><th rowspan="2">**Dépistage VIH** */HIV Screening* **P**=Positif **N**=Negatif **PF**=Pas fait</th><th rowspan="2">**Dépistage IST** */STI Screening* **P**=Positif **N**=Negatif **PF**=Pas fait **PA**=Pas applicable</th><th rowspan="2">**Dépistage Nutrition** *Screening Nutrition* **P**=Positif **N**=Negatif **PF**=Pas fait **PA**=Pas applicable</th><th rowspan="2">**Depistage NCDs/** Screening NCDs **P**=Positif (préciser NCD) **N**=Negatif **PF**=Pas fait **PA**=Pas applicable</th><th rowspan="2">**History of fever within 48hours O= Oui N=Non**</th><th rowspan="2">**T° Tem-perature**</th><th rowspan="2">**Examens Complémentaires/ Laboratoire** *Investigations / laboratory examinations*</th><th rowspan="2">**Resultats d'examens** *Examination results*</th><th rowspan="2">**Resultat Ex Parasi-tologique (TDR ou GE) P= Positif N=Negatif NA=Non Applica-ble**</th><th colspan="3">**Diagnostic** *Diagnosis*</th><th>**Traitement/ Mesures prises**</th><th rowspan="2">**Références Internes*** *Internal referrals*</th><th rowspan="2">**Entrée** *Date of admission*</th><th rowspan="2">**Sortie** *Date of exit*</th><th rowspan="2">**Nombre de jours d'hospi-talization** *Length of stay (days)*</th><th rowspan="2">**Motif de sortie (1,2,3,4,5)** *Reason for exit (1,2,3,4,5)*</th><th rowspan="2">**En haut** ID (Indangamuntu) **En bas Type d'assurance maladie (s)** (préciser) Type of health insurance **Si** / if **Mutuelle Numero** / Number</th></tr>
<tr><th>**Principal** *Main*</th><th>**Classifica-tion Malade** *Disease Code* (ICD-11)</th><th>**Secondaires** *Secondary*</th><th>*Treatment / Action taken*</th></tr>
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*:Références Internes :

Indiquez si c'est un transfert vers une autre Unité de soins et le mentionnez ou vers un autre service de soins (PIT) et le mentionez

‡ 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]