PART 2: OUTPATIENT REGISTER

HMIS FORM 031: OUTPATIENT REGISTER

DESCRIPTION AND INSTRUCTIONS

Objective: Used to record detailed information about each outpatient visit

Copies: One. This stays at the Health Unit and preferably in the Out Patients Department (OPD)

Responsibility: In-charge OPD

PROCEDURE:

1. The **DATE** the register was started; **NAME** of Health Unit and the date the register was finished are written on the front cover.

2. Pre-printed formats should be available for this register. However, in the event that they are not available, Counter books can be used. If counter books are used, then draw lines and write headings, as shown in the HMIS Form 031 below.

3. A specific list of diseases of national interest are monitored and reported monthly. The In-charge and **DHO** can determine additional diseases of local interest to monitor. For reporting, age is classified into two age groups: zero to four years, and five years and older. However, the exact age should be recorded in the register.

4. For each **new visit** and each **re-attendance visit,** a serial number is given. The total attendance, number of new attendance, re-attendance, referrals (in and out) and new diagnoses are counted and recorded in tables 1a and 1b on a daily basis . The count of new attendance and re-attendance is the total of all entries (Ticks) in the New attendance and Re-attendance columns respectively. The total attendance is the sum of the New and Re-attendances. The count of Referrals to the health unit is derived from the referrals listed in the **REF IN NUM** column and the count of Referrals out of the health unit is derived from the referrals listed in the **REF OUT NUM** column (Referral Number). The new diagnoses are counted from the **NEW DIAGNOSIS** column.

5. Special services, e.g. eye clinic, dental clinic, can use the same format. When separate clinics exist for children 0 to 4 years or for antenatal women, the same procedure should also be used. The clinics can monitor separately the diseases they diagnose; however, totals for the entire health unit are compiled together for reporting.

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HEADINGS AND COLUMN WIDTHS:

(1)	(2)	(3)		(4)	(5)	(6)	(7)	(8)	(9)	(10)	
SERIAL NUMBER	NAME OF PATIENT	RESIDENCE		AGE	MUAC	BMI	BLOOD PRESSURE	NEXT OF KIN	Need for palliative Care	TICK CLASSIFICATION	
				SEX	WEIGHT	Weight for Age Z Score				NEW ATTENDANCE CASE	RE-ATTENDANCE CASE
		VILLAGE	PARISH		HEIGHT/ LENGTH	Height/Length for Age Z Score	BLOOD SUGAR				
1 cm	5 cm	5 cm	4 cm	1 cm	1 cm	5 cm	2cm	5 cm	1 cm	1 cm	1 cm
SERIAL NUMBER	NAME OF PATIENT	VILLAGE	PARISH	AGE / SEX	MUAC / WEIGHT / HEIGHT/ LENGTH	BMI / Weight for Age Z Score / Height/Length for Age Z Score	BLOOD PRESSURE / BLOOD SUGAR	NEXT OF KIN	Need for palliative Care	NEW ATTENDANCE CASE	RE-ATTENDANCE CASE
SERIAL NUMBER	NAME OF PATIENT	VILLAGE	PARISH	AGE / SEX	MUAC / WEIGHT / HEIGHT/ LENGTH	BMI / Weight for Age Z-Score / Height/Length for Age Z-Score	BLOOD PRESSURE / BLOOD SUGAR	NEXT OF KIN	Need for palliative Care	NEW ATTENDANCE CASE	RE-ATTENDANCE CASE

(11)	(12)			(13)				(14)	(15)	(16)	(17)	(18)
Tobacco use / Alcohol use	MALARIA TEST			TB				NEW DIAGNOSIS	DRUGS / TREATMENT	DISABILITY (YES/NO)	REF. IN NUM	REF. OUT NUM
	FEVER (YES/ NO)	TESTS DONE (B/S, RDT/ND)	RESULTS (POS/NEG /NA)	New Presumed TB case (Y/N)	Patient sent to the Lab (Y/N)	Lab TB result (POS/ NEG/ NA)	Linked to TB clinic (Y/N)					
3cm	2cm	2cm	2cm	2cm	2cm	2cm	2cm	6 cm	12 cm	1cm	1 cm	1 cm
TOBACCO USE / ALCOHOL USE	(YES/ NO)	(B/S, RDT/ND)	(POS/NEG /NA)	(Y/N)	(Y/N)	(POS/ NEG/ NA)	(Y/N)	NEW DIAGNOSIS	DRUGS / TREATMENT	(YES/NO)	REF. IN NUM	REF. OUT NUM
TOBACCO USE / ALCOHOL USE	(YES/ NO)	(B/S, RDT/ND)	(POS/NEG /NA)	(Y/N)	(Y/N)	(POS/ NEG/ NA)	(Y/N)	NEW DIAGNOSIS	DRUGS / TREATMENT	(YES/NO)	REF. IN NUM	REF. OUT NUM

Note: A new line is started and a serial number provided for each attendance. However, **a new diagnosis is only recorded for a new attendance/case.**

A NEW ATTENDANCE/CASE is defined by a person who attends the health unit with a new episode of illness. If there are many diagnoses for one new attendance, use additional lines completing only column (14) and (15).

NEWLY DIAGNOSED:

To identify a person as having a new disease or condition by means of a diagnosis (this is subject to a medical analysis).

A RE-ATTENDANCE:

This refers to a person who attends the health unit for the second, third or higher number of visits for the same episode of illness as was previously diagnosed. **No diagnosis is recorded in the diagnosis column for a re-attendance.** However, you should still write all diagnoses in the patient cards.

DESCRIPTION OF COLUMNS:

Write the date on the first blank row. Nothing else is written on that row.

1. SERIAL NUMBER:

The numbers should start with "1" on the first date of each month. A new serial number is given to a patient who comes with a new diagnosis and those who come as re-attendances.

2. NAME OF PATIENT:

Write the patient's surname and the first name as an initial or in full as appropriate

3. RESIDENCE:

Write the Village and Parish of residence where the patient stays. It is important for geographical catchment and distribution of OPD population and diseases respectively.

4. AGE & SEX:

Write the patient's age in complete years if the patient is **over one year** of age. Write the patient's age in months if the patient is **under one year** of age and write clearly "MTH" after the age. Write the patient's age in days if the patient is less than **one month** of age and write clearly "Days" after the age.

Write the Sex (Gender) of the patient. Indicate **M** for male and **F** for female.

5. MUAC, WEIGHT AND HEIGHT/LENGTH

MUAC:

Take MUAC for clients above 6 months of age.

This is a measure of wasting. Write the MUAC colour code ("R" for red, "Y" for yellow and "G" for green) and the measurement in cm. Red is an indication of Severe Acute Malnutrition, yellow indicates Moderate acute malnutrition and green is normal nutrition status, If MUAC is Red or Yellow refer client to obtain the admission number from the Intergrated Nutrition Register (INR) which should be recorded in the register for nutrition rehabilitation.

WEIGHT:

Measure and record the weight of the client in Kilograms (Kg) on OUTPATIENT CARD. The measured weight should also be used to estimate the drug dosages to be administered

HEIGHT/LENGTH:

Measure and record the Height (for children above two years)/Length (For children 2 years and below) of the clients in centimeters (cm). Indicate as well, his/her height/Length on OUTPATIENT CARD**.**

6. BMI, WEIGHT FOR AGE Z SCORES AND HEIGHT/LENGTH FOR AGE Z SCORES

BMI

Calculate BMI by; weight (Kg)/ Height (m2). For calculation of BMI, height or length in cm should be converted to metres (m) by dividing height or length in m by 100.Write ND if Weight and/or Height is not taken

WEIGHT FOR AGE Z SCORES

This measure under weight. Weight for Age Z-scores (for clients less than 6 months) write "N" for normal nutritional status if client's Z-score are equal or above (>)-2SD And U for Underweight if client z score is less than (<)-2 SD

HEIGHT/LENGTH FOR AGE Z SCORES

This measures stunting, write "N" for normal nutritional status if client's Z-score are equal or above (>)-2SD And S for Stunting if the client z score is less than (<)-2 SD

7. **BLOOD PRESSURE & BLOOD SUGAR:**
   Record the patient blood pressure and Blood sugar level. Indicate ND if patient blood pressure and/or blood sugar level was not checked.

8. **NEXT OF KIN:**
   Write the names of the care taker (person) to be contacted in case of any follow up or emergency.

9. **NEED FOR PALLIATIVE CARE:**
   Tick if client needs palliative care if palliative care is not required put X

10. **TICK CLASSIFICATION:**

    NEW ATTENDANCE:
    Tick if the patient has a new case of illness, as defined above in the **note**.

    RE-ATTENDANCE:
    Tick if the patient is a re-attendance, as defined above in the **note**.

11. **TOBACCO & ALCOHOL USE:**
    Put a tick if patient uses tobacco in any form e.g. smoking, sniffing, chewing, shisha, smoking pipe. Put an X if patient does not use tobacco.

    Put a tick if patient consumes any type of alcohol e.g. local brew, beers, wines and spirits, Put an X if patient does not consume any type of alcohol.

12. **MALARIA TESTS:**
    Indicate Yes if client has fever. NO if client has no fever.
    Record the kind of test done i.e. **B/S** for microscopy
    RDT for Rapid Diagnostic Test
    ND if no test was done.
    Write **POS** for positive result, **NEG** for negative result and **ND** if no test done under result

13. **T.B**
    Record the **New Presumed TB Cases** from the triage corner. Record YES if it's a New Presumed case and NO if it's not a New Presumed case.

    If previous column is Y for yes, then record Y if a patient was sent to the LAB and N if the patient was not sent to the LAB.

    If the patient was sent to the lab and has results, then record the result POS for positive, NEG for negative and NA if Not Applicable

    If patient confirmed to have T.B basing on the results then record linked to the clinic with Y and N if not linked for treatment.

14. **NEW DIAGNOSIS:**
    Write clearly all diagnosis made. Diagnosis is written only once for a new attendance for the health condition. If more space is required, use another line. Remember that all diagnoses of notifiable diseases should be clearly **starred (*)** by the Serial Number.

NOTE: All diagnoses must be made according to the standard case definitions and Uganda Clinical Guidelines (UCG) provided by the Ministry of Health. The written diagnosis should correspond to one of the diagnoses listed in the Monthly Health Unit report (HMIS 105).

15. DRUGS / TREATMENT:

At a minimum, the names of the drugs/devices and quantities given in accordance with the age and/ weight of the patient. Quantities given should be written in the format: Number of units per dose x number of doses per day x number of days the drug is to be taken.

NOTE: In case of disability record the device given e.g. spectacles, wheel chair, walking stick, etc

16. DISABILITY:

Write YES if patient has any form of disability and NO if patient doesn't.

17. REF IN NUM:

Write in this column the referral number which was earlier indicated on the referral note, when the patient is referred to your health facility.

18. REF. OUT NUM:

If a patient is referred from your health facility to another health unit, a **REFERRAL NOTE** is written. The number on the **REFERRAL NOTE** is written in this column.

REPORTED DAILY: NOTIFIABLE DISEASES AND SUMMARISED WEEKLY

Any new case of Acute Flaccid Paralysis (AFP), Cholera, Dysentery, Guinea Worm, Meningococcal meningitis, Neonatal Tetanus, Plague, Rabies, Maternal Deaths, Perinatal Deaths, Measles, Yellow Fever and other Viral Hemorrhagic Fevers (VHF), Adverse Events Following Immunization (AEFI) Influenzae Like Illness (ILI), Presumptive TB cases etc.

[To make it easier, every notifiable disease patient should be starred (*) by the Serial Number]

REPORTED MONTHLY

The number of new attendances, re-attendance, referrals in and out, and diagnoses.

The number of diagnoses for the nationally selected diagnoses and for the diagnoses of local interest, by age groups (0-28 days, 29days - 4years, 5 – 59 years and 60 years and above).

Other information as requested for and required by the In-Charge.