Recording additional information on the visit

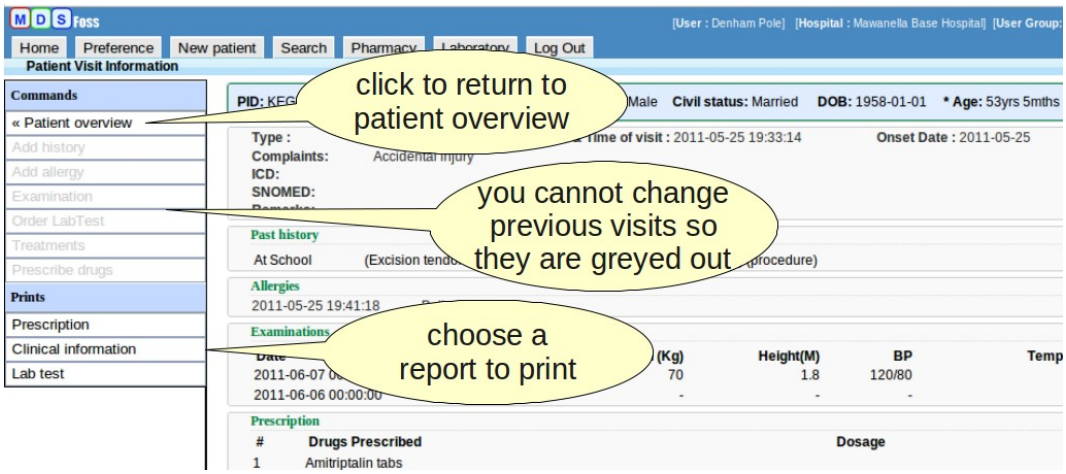
Patient overview screen

When you select a patient from the search screen, the system shows the *Patient Overview* screen. This displays all the contacts between this patient and the hospital: visits and admissions together with past history and allergies. In the menu on the left of the screen there are *Commands* to record various activities for this patient. This is followed by *Prints* which allows to print reports referring to this patient (but not prints related to a specific visit). In the third section on the left, doctors are shown the recent patients where they have entered information.

In this example the test patient with hospital registration number 9 has 1 visit and 1 admission. There is one past history item and 1 allergy recorded. These are shown in the four yellow windows under the blue patient information banner. In order to see more detail on one of these visits, click on the row for this visit in the top yellow window. This opens up the *Patient Visit Information* screen.

Patient Visit Information screen

When you save the information from the *Visit* screen, the next screen shown is the *Patient Visit Information*.



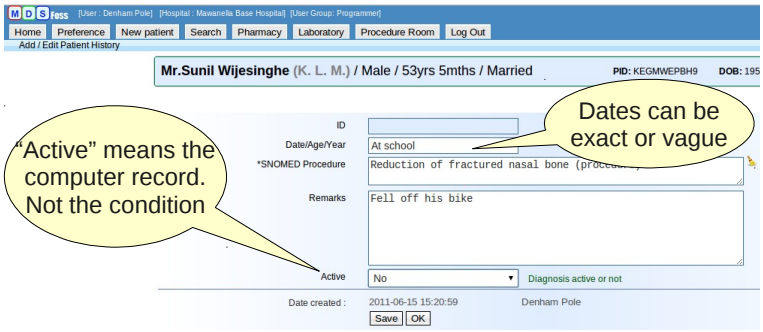
This screen gives an overview of all the information stored for the visit (Complaints, Examination, Lab-tests, Prescriptions and treatments) as well as Past history and Allergies.

Each set of information relating to this visit is shown in a separate small window. Each of these windows can be opened to edit the data by clicking on the pencil icon on the right. If the visit was today, data can be changed, but after one day it is fixed and cannot be changed. The only exception to this rule is that *Remarks* can be added.

The menu on the left of the screen is confined to *Commands* and *Prints* that refer to a single visit.

Add past history

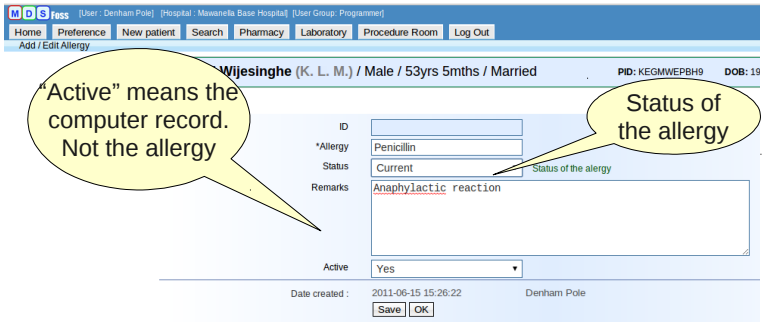
Once a visit has been recorded it is possible to record an item of past history. The SNOMED database is used to select an event or disease that occurred in the past. The date can be given approximately – for example just the year or a time-period such as “At school”.



Add allergies

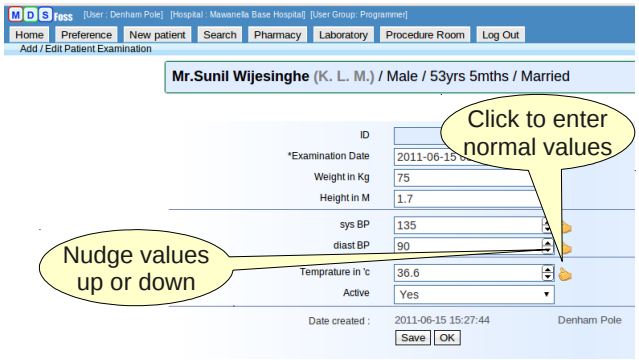
Once a visit has been recorded it is possible to record an allergy. Currently free text is entered.

The “Status” of the allergy means whether it is currently active or just a historical fact. The term “Active” is used in this system to show whether an item should be ignored. No data is actually deleted from the database but is just shown as inactive (scored out on the patient overview screen).



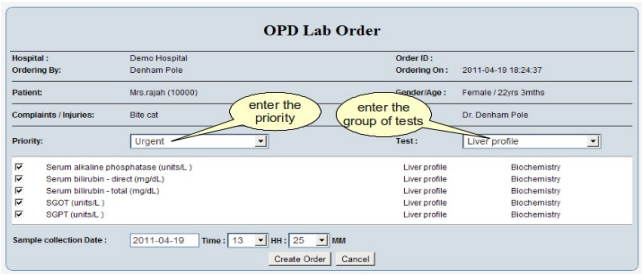
Examination

If the patient is examined during a visit, the findings can be recorded on this structured screen. The normal values for the numerical fields can be entered by clicking on the hand icon. They can also be nudged up or down using the arrows at the end of the boxes.



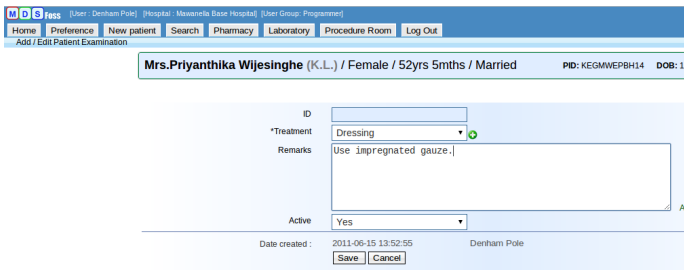
Order lab-tests

On this screen, the doctor can order lab tests for the patient who had this OPD visit. The tests are sorted by department (e.g. Haematology, Biochemistry...) and within each department tests are grouped so that they can be ordered together (e.g. Urine screen, Lipid profile...). Tests in the group not required for this patient can be removed from the list.



Order treatments

On this screen, the doctor can order treatments for the patient who had this OPD visit. Treatments not in the list can be added using the Data Table module.



Prescribe drugs

On this screen, the doctor can prescribe drugs for the patient. The first pop-up window on the left shows the list of drugs available in the dispensary and for each preparation, the number of doses remaining in stock. The other pop-up windows allows you to record the frequency and the duration of the drug prescribed. This helps the dispensary to choose the appropriate number of doses to be dispensed.