



ጅማ የህክምና ማዕከል

ግዚያዊ የህመማን መመዝገቢያና የአገልግሎት ክፍያ መረጃ መያዣ ፎርም

| | | | |
|--------------------------------|--------------------------------|--|------------------------|
| ስም _____ | የአባት ስም _____ | የአያት ስም _____ | ካርድ ቁጥር _____ |
| የትውልድ ቀን _____ / _____ / _____ | ፆታ _____ | የውል አይነት _____ | ኢንዱስትሪ _____ ክልል _____ |
| ዞን _____ | ወረዳ/ድርጅት _____ | ቀበሌ _____ | ስልክ _____ |
| CBHI#ID/ደብዳቤ ቁጥር _____ | የመጣበት ቀን _____ / _____ / _____ | ኢንካውንተር: <input type="checkbox"/> ተኝቶ ታካሚ <input type="checkbox"/> ተመላላሽ ታካሚ | |

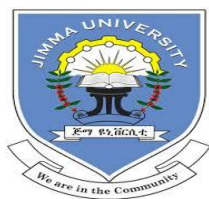
| # | ካርድ ክፍያ | የመድሃኒት ክፍያ | ፕሮሲጀር ክፍያ | ኢሜጅንግ ክፍያ | የምርመራ ክፍያ | የአልጋ ክፍያ | ሌላ |
|----------------------------------|--------------------------------|------------|-----------|-----------|-----------|----------|----|
| Service charge fee filling table | | | | | | | |
| | It must be Birr 0,5 or 10 Birr | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| #Total | | | | | | | |

Remark

Outcome: ☐ Died ☐ Back-referral ☐ Higher referral ☐ Scape ☐ Discharged

Reason out: ☐ Drug stock-out ☐ Medical Service ☐ Better-healed

የመዘገበው _____



Jimma Medical Center

Patient Registration form and Service charge fee collection form

First Name_____Middle Name_____Last Name_____MRN_____

BirthDate____/____/____Sex_____Agreement_____Indigent_____Region_____

Zone_____Woreda/Org_____Kebele_____Phone_____

CBHI#ID//Letter No_____Coming date____/____/____Encounter: ☐ IPD ☐ OPD

| # | Card fee | Drug fee | Procedure fee | Imaging fee | Laboratory fee | Bed fee | Others |
|----------------------------------|--------------------------------|----------|---------------|-------------|----------------|---------|--------|
| Service charge fee filling table | | | | | | | |
| | It must be Birr 0,5 or 10 Birr | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| #Total | | | | | | | |

Remark

Outcome: ☐ Died ☐ Back-referral ☐ Higher referral ☐ Scape ☐ Discharged

Reason out: ☐ Drug stock-out ☐ Medical Service ☐ Better-healed

Recorded by_____