OPD - Outpatient Department

Over the years, hospitals have been crucial to humans as they help people lead healthy lives. Through their service, hospitals save people from various diseases, which even include life-threatening diseases. Different departments of hospitals efficiently contribute to the success of any hospital. The major departments in the hospital are **Dietary department, Inpatient service (IP), Medical department, Nursing department, Operation theatre (OT), Outpatient department (OPD), Rehabilitation department, Radiology department, and Paramedical department**. The outpatient department is the first intermediary between a patient and the hospital staff. A patient first comes to the OPD for inspection and then the doctors from the OPD refer him/her to the respective departments of treatment according to the patient needs.

What is an OPD?

OPD is the short form of the Outpatient Department. It is the section of any hospital where the patients that require medical attention are treated. People need to pay consultation charges, and the doctor will visit the patient to conduct the necessary check-up. The doctor examines the patient, conducts necessary tests, and prescribes medication and treatment on the basis of the health condition of the patient.

Hospitals have OPD wards for providing attention to the patients and conducting medical treatment.The minor surgeries and treatments can be easily conducted in the OPDs. It is not necessary to admit a patient to the hospital for surgeries and treatment.

Moreover, modern OPDs have the necessary equipment and facilities to conduct surgeries, medical tests, and diagnoses.

Services Provided by the OPD

OPDs provide all general services and facilities which are necessary for any hospital. OPDs act as the first step for consulting the doctor and getting the tests done to proceed with treatment. Through the services provided in OPD, the hospital works for the smooth functioning of the healthcare system. These services are classified as -

- **Prevention and wellness -**
  OPDs provide guidance to the patients for overall wellness and prevention of health issues. Doctors guide patients to maintain a healthy weight, improve sleep, balance sugar levels, etc.
- **Diagnosis -**
  OPD is the first place where the patient and doctor meet and discuss the patient's health condition. After discussing the issue, the doctor suggests the necessary tests for the patient. The lab tests and MRI scans are conducted in the OPD.
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- **Treatment -**
  Treatment and minor surgeries can be done in the outpatient department. Modern OPD has all the necessary equipment to treat a patient. Surgeries such as cuts, wounds, etc., can be easily handled in the modern OPD.

Importance of OPD in Healthcare Systems

- An Outpatient Department is at the entrance of any hospital. It acts as the first place where the patients and doctors communicate.
- It is a crucial link between the patients and the healthcare system and is hence inseparable.
- It is vital in preventing diseases and ensures fast recovery of the patient.
- It controls the number of patients in the inpatient ward by providing small surgeries and treatments.
- It evaluates the patients, and only those who require a bed or special care are shifted to the inpatient ward. Thus, saving the number of occupied beds.

- Generally, people that visit for the first time and have minor health are treated in OPD. Doctors conduct tests, provide consultancy, and give prescriptions to the patient in the OPD.

Process of Admission in the Outpatient Department

There is a certain process that is to be followed while treating the patients in the OPD. It includes the following:

1. The patient is screened, and tests are conducted as an initial process.
2. The patients are allotted appointments for consulting a doctor.
3. A new patient must maintain a file that can be issued at reception.
4. A patient is generally charged for consultation on the basis of whether they are a new patient or it is their follow-up.

An Electronic Medical Record (EMR) system is a software platform that allows the electronic entry, storage, and maintenance of digital medical data. From a patient perspective, it is a digital version of a patient's medical information that would have previously been recorded in a paper chart. Sometimes the term Electronic Health Record (EHR) is used to describe data that includes medical info entered outside of an office or hospital visit. For purposes of this page, I mostly use EMR to describe the clinical and technical components of the software.
EMR systems are used throughout a healthcare organization to document clinical information on many patients over long periods. The systems organize and present data in ways that assist clinicians with interpreting health conditions, with placing orders, and providing ongoing care, scheduling, billing, and follow up.
Data contained in the EMR is also used to create reports for clinical care, disease management, patient communications, and more.

An EMR will typically be accessed by users from a Windows based PC, a tablet, or a Smartphone. Some EMRs are entirely web-based, meaning that the organization using the technology accesses it only from a web browser as opposed to maintaining application servers and database servers. The application and databases are managed and located with the EMR vendor.
Alternatively, many EMRs (especially in large organizations) are not entirely web-based. An example would be a hospital that uses an enterprise wide system such

as Epic, Cerner, or MEDITECH. This graphic shows a simplified view of how these EMR systems are configured:

Before the days of EMRs, your medical info was usually entered by hand and by filling out forms in a paper chart binder. Paper charts had a designated order in which the medical information was organized. This is important to cover because the paper chart structure has influenced the workflow and layout of today's EMRs. Here are the tabs contained in a paper chart:

Face Sheet

A face sheet is a quick view of the patient, containing basic demographic info such as age, gender, address and phone number. It also has an overview of the patient's medical condition, allergies, and current medications. In an EMR, this overview may be called a Snapshot or Synopsis.

Medical Encounters

This includes events that have occurred in which you interacted with a care provider. Regular office visits, trips to the ER, immunizations, hospital stays, and even telephone calls to your doctor's office are all encounters, and are recorded in your medical record.

Progress Notes

This is where the physician and other caregivers document their assessment, impressions, and other data observed during visits with patients.

Orders and Prescriptions

Any time a healthcare provider prescribes a medication, orders an X-Ray, or even advises you wear a knee brace- these are all orders and are documented in your medical record.

Test Results

Results from your lab tests, MRIs, or any other diagnostic tests will be in this section.

Other information and documents from other healthcare providers

This is where any miscellaneous documents or materials are kept. For a paper chart, it's usually near the end.

Intake – Reason for Visit and Vital Signs

When you arrive in the exam room, the Medical Assistant will open your medical record, usually by clicking on your name from the schedule. They will then confirm what you are being seen for and document it. If you are being seen for abdominal pain, that's exactly what they will enter in the EMR. It's important to note that this is not a diagnosis, just a reported observation.Next, vital signs are taken. Federal regulations for Meaningful Use of Electronic Medical Records systems require at least the gathering of height, weight, and blood pressure.

Patient Reported Medications

The MA will then ask you what medications you are on and record them in the EMR. They should ask for name, dosage, strength, and frequency. In the EMR, there will be a medications area that has your current meds list, and a prescriptions area, which has the prescriptions that your doctor may write for you. These are separate areas in the EMR, and the MA typically just documents the reported meds you are taking.