MINISTRY OF HEALTH

HMIS OPD 002:
OUTPATIENT REGISTER

NAME OF HEALTH FACILITY: .....CODE.....LEVEL.....

SUBCOUNTY/DIVISION:.....

HSD:.....

DISTRICT:.....

DATE OPENED..... DATE CLOSED:.....

Print Version September 2019

HMIS OPD 002: OUTPATIENT REGISTER

Ministry of Health

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. 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 5 years and above, 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.

DESCRIPTION OF COLUMNS:

Write the date on the first blank row. Nothing else is written on that row. Write in the format dd/mmm/yyyy. The month should be abbreviated in the form Jan, Feb, …Dec

1. SERIAL NO:

Write the patient serial number. Start with “001” at the beginning of every month.

2. NIN:

The patient’s National Identification Number, or refugee number or passport number in case of foreigners

3. NAME OF PATIENT AND CONTACT:

Write the patient’s surname, the first name in full and Tel. contact.

4. AGE:

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.

5. SEX:

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

6. PATIENT’S CATEGORY:

Record the origin of the patient if the patient is a Ugandan,

write **“N”** for National if patient is a Ugandan, **“R”** for Refugee, if the Patient is a Refugee and **“F”** for Foreigner if the patient is a foreigner.

7. RESIDENCE:

Write the Village, Parish, Sub-county/Division and District of residence where the patient stays. It is important for geographical catchment and distribution of OPD population and diseases respectively.

8. NEXT OF KIN AND CONTACT:

Write the names of the next of Kin Telephone contact and relationship to Client to be contacted in case of any follow up or emergency.

9. NUTRITION ASSESSMENT:

WEIGHT: Measure and record the weight of the client in Kilograms (Kg). Indicate as well, his/her Weight on the OUTPATIENT CARD or Medical Form 5. The measured weight should also be used to estimate the drug dosages to be administered.

HEIGHT/LENGTH: Measure and record the client’s Height (for clients above two years) or Length (For children 2 years and below) in centimetres (cm). Indicate as well, his/her Height/Length on the OUTPATIENT CARD or Medical Form 5.

MID-UPPER ARM CIRCUMFRENCE (MUAC): This is a measure of wasting. Take MUAC for clients above 6 months of age and record the measurement in cm and the colour code in brackets. Write the MUAC colour code (“R” for Red, “Y” for Yellow and “G” for Green). Write “ND” for Not Done, if the client was not assessed for nutritional status using MUAC Tape. Red is an indication of Severe Acute Malnutrition, Yellow indicates Moderate acute malnutrition and Green is normal nutrition status.

WEIGHT FOR HEIGHT/LENGTH Z-SCORE: This is a measure for wasting. For children aged 0-5years, record the Weight for Height/length Z-score and the corresponding code in brackets. Write; “SAM-O” if the client’s Z-score is <-3SD and child has oedema of any grade; write “SAM” if the client’s Z score is <-3SD and the child has no Oedema; write MAM if the client’s Z-score is ≥-3SD and < -2SD; write “N” for normal nutritional status if client’s Z-score is equal or above -2SD ; Write “ND” for Not Done,

WEIGHT FOR AGE Z SCORES: This is a measure for underweight. Weight for Age Z-scores (for clients 0-59months) write “N” for normal nutritional status if client’s Z-score is equal or above -2SD and U for Underweight if client Z-score is ≥-3SD and <-2SD; write “SU” if the client’s Z-score is <-3SD to indicate severe underweight; Write “ND” for Not Done

HEIGHT/LENGTH FOR AGE Z SCORES: This is a measure for stunting in children 0-59months. write “N” for normal nutritional status if client’s Z-score is equal or above -2SD and S for moderate stunting if client Z-score is ≥-3SD and <-2SD; write “SS” if the client’s Z-score is <-3SD to indicate severe stunting. Write “ND” for Not Done,

BMI for Age Z-Score: For children aged 5-9 years and adolescents aged 10-19 years, record the BMI for Age Z-score and the corresponding code in brackets.

Write ‘N’ for Normal if client’s Z-score is ≥ -2SD and ≤ +2SD; ‘MM’ for moderately Malnourished if client’s Z-score is <-2SD and ≥-3SD; ‘SM’ for Severely Malnourished if client’s Z-score is <-3SD; ‘OW’ for Overweight

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if client's Z-score is > +2SD and ≤+3SD; and 'O' for Obese if client's Z-score is > +3SD. Write 'ND' for Not Done if the client was not assessed for nutritional status using BMI for Age Z-score.

Body Mass Index (BMI): For adults aged 19 years and above (excluding pregnant women and Lactating mothers 6 months postpartum), record the BMI and the corresponding code after calculating the BMI. Write 'N' for Normal if client's BMI is ≥18.5 and ≤24.9; 'MM' for Moderately Malnourished if client's BMI is ≥16.0 and ≤16.9; 'SM' for Severely Malnourished if client's BMI is <16.0; 'OW' for Overweight if client's BMI is ≥25.0 and ≤29.9; and 'O' for Obese if client's BMI is ≥30.0. Write 'ND' for Not Done if client was not weighed or height not measured.

BMI Formula: BMI = weight (Kg)/ Height (m2). For calculation of BMI, height in cm should be converted to metres (m) by dividing height in cm by 100.

NOTE: If MUAC measurement or W/H or L Z-score indicates Red (SAM) or Yellow

(MAM), refer client to the nutrition unit/corner within the health facility (or another health facility in case your health facility does not provide SAM or MAM treatment services); for enrolment into care and assignment of an INR number which should be recorded in the Integrated Nutrition Register. For clients found to be with SAM or MAM, indicate this under the diagnosis column together with any other condition diagnosed.

10 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.

11. NEED FOR PALLIATIVE CARE:

Tick if client needs palliative care if palliative care is not required put X

12. TOBACCO USE, EXPOSURE & 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 a patient is exposed to Tobacco in any form e.g. Smoking, chewing, shisha, smoking pipe. Put an "X" if the patient is not exposed to tobacco use.

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.

13. 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

14 TUBERCULOSIS (TB):

Record the New Presumed TB Cases from the triage corner. Record YES if it's a New Presumed case and NO ifit's not a New Presumed case.
If previous column is yes, then record "Y" for yes if a patient was sent to the LAB and "N" for No if the patient was not sent to the LAB.

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

Write "Y" for yes, If the patient was screened for HIV and "N" for no if the patient was not screened for HIV.
Write "Y" for yes, If the patient is eligible for HIV testing and "N" for no if the patient is not eligible for HIV screening.

If patient confirmed to have T.B basing on the results then record linked to the clinic with Y for yes and N for no if not linked for treatment.Please record where and the client TB Number given.

15. 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**.

16. **DIAGNOSIS:**

Write clearly all diagnosis made. 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).

17. PRESCRIPTION:

At a minimum, the names of the drugs/devices and quantities given in accordance with the age and/ weight of the patient. Quantities prescribed 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

18. DISABILITY:

Write the disability codes as indicated in the table for disabilities

19. **REF IN NUM:**

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

20. 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.

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Name of Health Facility.. **Month**... **Financial Year**...

(1) Serial Number	(2) NIN	(3) Name	(4) Age	(5) Sex (M/F)	(6) Client Category (Write N/R/F)	(7) Residence	(8) Next Of Kin Name And Contact	(9) Nutrition Assessment: MUAC (cm +(R/Y/G/ND) / Weight (Kg) / Height/ Length (cm)	(9) Nutrition Assessment: BMI (SM/MM/N/OW/O) / BMI For Age (SM/M/N/OW/O) / Weight For Age Z Score (SU/U/N/OW/O) / Height/ Length for Age Z Score (N/S/SS)	(9) Nutrition Assessment: W/H Or L Score (Z Score)	(10) Blood Pressure (mmHg) / Blood Sugar (mm/l)	(11) Need For Palliative Care (✓/X)	(12) Tobacco Use / Tobacco Exposure / Alcohol Use
		Surname Given name Phone contact		M/F	N/R/F	Village Parish Subcounty/Division District	Surname Given name Phone contact Relationship	MUAC Cm + (R/Y/G) Weight Kg Height/ Length (cm)	BMI (SM/MM/N/OW/O) BMI For Age (SM/MM/N/OW/O) Weight For Age Z-Score (SU/U/N/OW/O) Height/ Length for Age Z Score (N/S/SS)	W/H Or L Score (Z Score)	MmHg/ND mm/l /ND	(√ /X)	Tobacco use Tobacco exposure Alcohol use
		Surname Given name Phone contact		M/F	N/R/F	Village Parish Subcounty/Division District	Surname Given name Phone contact Relationship	Cm (R-O/R-WO/Y/G) Kg Cm	BMI (SM/MM/N/OW/O) BMI For Age (SM/MM/N/OW/O) Weight For Age Z-Score (SU/U/N/OW/O) Height/ Length for Age Z Score (N/S/SS)	W/H Or L Score (Z Score)	MmHg/ND mm/l /ND	(√ /X)	Tobacco use Tobacco exposure Alcohol use
		Surname Given name Phone contact		M/F	N/R/F	Village Parish Subcounty/Division District	Surname Given name Phone contact Relationship	Cm (R-O/R-WO/Y/G) Kg Cm	BMI (SM/MM/N/OW/O) BMI For Age (SM/MM/N/OW/O) Weight For Age Z-Score (SU/U/N/OW/O) Height/ Length for Age Z Score (N/S/SS)	W/H Or L Score (Z Score)	MmHg/ND mm/l /ND	(√ /X)	Tobacco use Tobacco exposure Alcohol use
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		Surname Given name Phone contact		M/F	N/R/F	Village Parish Subcounty/Division District	Surname Given name Phone contact Relationship	Cm (R-O/R-WO/Y/G) Kg Cm	BMI (SM/MM/N/OW/O) BMI For Age (SM/MM/N/OW/O) Weight For Age Z-Score (SU/U/N/OW/O) Height/ Length for Age Z Score (N/S/SS)	W/H Or L Score (Z Score)	MmHg/ND mm/l /ND	(√ /X)	Tobacco use Tobacco exposure Alcohol use
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Note: A new line is started, and a serial number provided for each attendance. However, a new diagnosis is only recorded for an attendance/case.

MUAC Codes:
R = Red, **Y =** Yellow,
G = Green
ND = Not Done,

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Name of Health Facility.. Month.................................. Financial Year..................................

(13)			(14)				(15)		(16)	(17)	(18)	(19)	(20)
MALARIA TEST			TB				TICK CLASSIFICATION		Diagnosis	Prescription	Disability	Ref. In No.	Ref.out No.
Fever (Yes/ No)	Tests Done (B/S, RDT/ND)	Results (POS/ NEG /NA)	Presumed TB Case (Y/N) Screened for HIV (Y/N) Eligible for HIV Testing (Y/N)	Patient Sent To The Lab for TB testing (Y/N)	Lab. TB Result (POS/ NEG/ NA)	Linked To TB Clinic (Yes/No) Where Unit TB No.	New Attendance	Re - Attendance			(Write code of disability)		
(YES/ NO)	(B/S, RDT/ND)	(POS/NEG /NA)	Presumed TB Case (Y/N) Screened for HIV (Y/N) Eligible for HIV Testing (Y/N)	(Y/N)	(POS/ NEG/ NA)	(Y/N) Where Unit TB No.							
(YES/ NO)	(B/S, RDT/ND)	(POS/NEG /NA)	Presumed TB Case (Y/N) Screened for HIV (Y/N) Eligible for HIV Testing (Y/N)	(Y/N)	(POS/ NEG/ NA)	(Y/N) Where Unit TB No.							
(YES/ NO)	(B/S, RDT/ND)	(POS/NEG /NA)	Presumed TB Case (Y/N) Screened for HIV (Y/N) Eligible for HIV Testing (Y/N)	(Y/N)	(POS/ NEG/ NA)	(Y/N) Where Unit TB No.							
(YES/ NO)	(B/S, RDT/ND)	(POS/NEG /NA)	Presumed TB Case (Y/N) Screened for HIV (Y/N) Eligible for HIV Testing (Y/N)	(Y/N)	(POS/ NEG/ NA)	(Y/N) Where Unit TB No.							
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(YES/ NO)	(B/S, RDT/ND)	(POS/NEG /NA)	Presumed TB Case (Y/N) Screened for HIV (Y/N) Eligible for HIV Testing (Y/N)	(Y/N)	(POS/ NEG/ NA)	(Y/N) Where Unit TB No.							
(YES/ NO)	(B/S, RDT/ND)	(POS/NEG /NA)	Presumed TB Case (Y/N) Screened for HIV (Y/N) Eligible for HIV Testing (Y/N)	(Y/N)	(POS/ NEG/ NA)	(Y/N) Where Unit TB No.							

Disability Codes:
1. Difficulty in seeing.
2. Albinism.
3. Difficulty in hearing.
4. Delayed age specific motor development (turning, sitting, crawling, standing and walking as indicated on the child health card).
5. Difficulty in walking.
6. Difficulty in understanding
7. Difficulty in remembering.
8. Difficulty in reading.
9. Difficulty in writing.
10. Difficulty washing all over or dressing.
11. Mentally impaired.
12. Emotionally impaired

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