
 OSPITAL NG PARAÑAQUE 		Document Code: OSPAR-ADM-ADMITTING-002
		Issue Date:
ADMINISTRATIVE DIVISION APPROVAL MATRIX		Section / Department ADMITTING SECTION
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Policy Title: POLICY ON PATIENT REGISTRATION		
Prepared By: Dianne B. Bernas MMPA OIC Admitting Section	Reviewed By: Arnaldo S. Cortes, RN Supervising Administrative Officer Darius J. Sebastian, MD, MPH, PHSAE Hospital Administrator	Approved by: Jefferson R. Pagsisihan, MD, MHM Hospital Director

INTRODUCTION

The Admitting Section is generally the patient's first point of contact with the hospital. The hospital admitting staff is responsible for all patients' admission or registration of individuals when they enter Ospital ng Parañaque I for laboratory tests, OPD checkup, Prenatal checkup or emergency treatment.

OBJECTIVE: The policy shall aim to provide systematic procedures in gathering patient information and [recording them into designated logbooks.



COVERAGE: This policy shall cover this section.

RESPONSIBILITIES:

- I. It shall be the sole responsibility of this section to gather accurate information on all the clients of this institution and to follow the system of recording as adopted from that of the other government hospitals.
- II. It shall be the responsibility of the Nursing Staff to inform the Admitting Section for any connection.
- III. It shall be the responsibility of the Admitting Staff to make correction with their corresponding initials.

POLICY:

- I. This policy shall enforce the importance of acquiring accurate but concise information on all clientele of this institution as this can be a valuable source of data for their thorough medical evaluation and examination by the medical staff.
- II. This policy shall also ensure that all data sourced are verified and up to date at all times.

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PROCEDURE:

- I. Classification of patients shall be indicated in all issued slips for constitution, whether from ER or OPD.
- II. FOR NEW PATIENTS:
 - a. This office shall include the following information on interview: Full Name (given, middle, and last), age/sex, complete and present address, birth date and birth place, and signature of patient or authorized representative.
 - b. A unique Hospital Number shall be assigned to each entry into the logbook to eliminate confusion and duplication.
 - c. This regard shall be issued to patient prior to proceeding, to area of consultation.
- III. FOR OLD PATIENTS:
 - a. Patient and/or relative shall be asked to proceed to the Medical Records Section, if open, to secure to old records. If closed, this section shall issue a temporary OPD chart bearing the following information: Hospital Number, Full Name, Age, and Sex.
 - b. Recording shall likewise be done by this section.
 - c. Patient and/or relative shall proceed to area of consultation.
- IV. All patients for OPD consultation shall be issued number before proceeding for registration.
- V. If patient at ER for consultation, a corresponding ER slip shall be issued with complete name of patient with properly classified ML or not.

Implementation Date:

This policy has been implemented since 1978 with some revisions made to adopt to the new system of patient recording.

Schedule for Policy Review:

This policy shall be reviewed every two (2) years or as deemed necessary