Admission Date ..... / ...../ 2022

Discharge Date ..... / ...../ 2022

OLJABET HOSPITAL NYAHURURU

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www.oljabethospital.co.ke

'Healthcare that cares'

0722624363 /0703333111

WARD: MALE ☐ FEMALE ☐ PEDIATRIC ☐

IP NO:

GENERAL WARD FILE

NAME:_____ **AGE:**_____ **GENDER:**_____

CONTACT:_____ **RESIDENCE:**_____

ID NO:_____ **MEMBER NO:**_____

M.O.P _____ **RELIGION:** _____

N.O.K _____ **RELATIONSHIP:**_____

CONTACT:_____ **RESIDENCE:**_____

STRICTLY CONFIDENTIAL

PATIENT FILE SUMMARY

ALL COPIES OF LETTERS, DISCHARGE SUMMARIES, RADIATION SHEETS, MUST BE ATTACHED AS THIS INFORMATION MAY BE ONLY OBTAINED FOR FUTURE REFERENCE.

CASE INDEX

DATE ADMITTED	DATE DISCHARGED	PRIMARY DIAGNOSIS	CODE	OTHER DIAGNOSIS	CODE

ADMISSION PROTOCOL *(tick every step completed)*

- ☐ Member Produces ID Card for Verification.
- ☐ Admitting Officer Photocopy's Member / Patient ID and adds to files.
- ☐ Admitting Officer Fills; Cover Details, Patient Particulars Form, Hospital Claim Form.
- ☐ Member Signs Declaration form, Consent form and Insurance Form.
- ☐ Admitting officer transfers Patient to the ward.
- ☐ Admitting Officer adds ICD10 to NHIF system.
- ☐ Patient Identification wrist band fixed.

(This protocol is disregarded in cases of emergencies)

DISCHARGE PROTOCOL *(tick every step completed)*

- ☐ Discharge Officer Initiates Clearance Form.
- ☐ Discharging officer fills the Discharge Summary and Makes sure all details have been captured.
- ☐ Discharging officer takes the file to Accounts for Charge sheet input and Copy of Receipts where applicable.
- ☐ Accounts send file to Records.
- ☐ Records sends to File to Nursing Officer In-Charge for Final Clearance and Discharge.
- ☐ Patient is allowed to leave.
- ☐ Nursing Officer In-Charge sends File to General Manger.

Admitting Officer's Name: ……..

Discharge Officer's Name: ……

PATIENTS DECLARATION

I hereby certify that I have produced to Oljabet Hospital, my Identification Card, contact information and Insurance details, which is duly paid up-to-date and that the particulars provided are correct. I hereby authorize the Insurance company to reimburse / pay Oljabet Hospital all amounts that is due.

Patient's Signature ..... Date .....

PATIENT PARTICULARS

1. Names ……
2. ID No. ……
3. Gender ……
4. Date of Birth ……. / ……. / …….
5. Age ……
6. Insurance Provider ……
7. Insurance Member No. ……
8. Patient / Contributors Telephone No. ……
9. Patients Relationship to Contributor (Self, Spouse, Child) ……
10. Name of Person Accompanying Patient or Next of KIN ……
11. Telephone No. of Person Accompanying Patient or Next of KIN ……
12. Relationship of Person Accompanying Patient ……
13. Admitting Officers Names…… Sign……

IP No……. BED No……

PATIENTS DECLARATION

I hereby certify that I have produced to Oljabet Hospital, my Identification Card, contact information and Insurance details, which is duly paid up-to-date and that the particulars provided are correct. I hereby authorize the Insurance company to reimburse / pay Oljabet Hospital all amounts that is due.

Patient's Signature ..... Date .....

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PATIENT CONSENT FORM

I, ... do hereby give consent for myself / Child / Spouse to undergo treatment / Operation (s) which has been explained to me by the doctor.

I also give consent for Anesthesia or any other procedure (s) / operation (s) that the doctor will deem appropriate to save life.

I have not been guaranteed that a particular doctor will perform the treatment (s) / operation (s).

Patient's Signature ..... Date .....

Doctor's Signature ..... Date .....

Witness Signature ..... Date .....

ADMISSION FORM

CHIEF COMPLAINTS

.....

.....

.....

.....

HISTORY OF PRESENTING ILLNESS

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PAST MEDICAL & SURGICAL HISTORY

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OBS / GYN

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FAMILY HISTORY

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SOCIAL HISTORY

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REVIEW OF SYSTEMS

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CURRENT MEDICATION

.....

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Vital Signs - Pulse Rate ..... BP.....Temp.....Resp. Rate.....

RESPIRATORY SYSTEM (R/S)

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.....

.....

CADIOVASCULAR SYSTEM (CVS)

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……

……

PER ADBOMEN (P/A)

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……

……

CNS

……

……

……

……

IMPRESSION

……

……

……

……

PLAN

……

……

……

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DOCTOR'S NOTES

Date:

Time:

DOCTOR'S NOTES

Date:

Time:

TREATMENT SHEET

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Patient Name..... IP No. .....

ONCE ONLY PRESCRIPTIONS, STAT DOSES, PRE-MED. ETC

DATE	ROUTE	DRUG	DOSE	NAME & SIGNATURE	TIME	NOTES

REGULAR PRESCRIPTIONS

DATE	ROUTE	DRUGS	DOSE	FR	DU	NAME / SIGN	AM		PM		AM		PM		AM		PM		AM		PM		AM		PM		AM		PM		AM		PM	

NOTE:
All prescriptions must be re-written weekly. Not later than Monday mid-day
Use Red Pen for DDA
Drug Allergies.

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NURSING CARE PLAN

NAME of PATIENT …… **DX** ……

IP No. …… **DOA** …… **BED NO.** ……

DATE / TIME	ASSESMENT DATA	NURSING DIAGNOSIS	OBJECTIVES	PLAN OF ACTION	RATIONAL	IMPLEMENTATION	EVALUATION	SIGN

CARDEX

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Patient Name.....

IP No..... **DOA** .....

AGE ..... **GENDER** ..... **WARD** ..... **BED No.** .....

Diagnosis .....

Operation .....

Doctor Name..... **Nurse Name** .....

DATE	TIME	REMARKS	SIGNATURE

OLJABET HOSPITAL

FOUR HOUR TEMPERATURE & BP CHART

DISEASE

NOTES OF CASE

.....

.....

.....

NAME { .....

.....

Age.....

I.P. NO.....

DATE OF ADMISSION

.....

DATE / DAY of DISEASE / TIME																																			
	Morning			Evening			Morning			Evening			Morning			Evening			Morning			Evening			Morning			Evening			Morning			Evening		
	3	7	11	3	7	11	3	7	11	3	7	11	3	7	11	3	7	11	3	7	11	3	7	11	3	7	11	3	7	11	3	7	11	3	7	11
R																																			
42																																			
39																																			
36																																			
33																																			
30																																			
27																																			
24																																			
21																																			
18																																			
15																																			
12																																			

R	P	T	BP
42	155	107°	270
			260
39	145	106°	250
			240
			230
36	135	105°	220
			210
33	125	104°	200
			190
			180
30	115	103°	170
			160
27	105	102°	150
			140
24	95	101°	130
			120
21	85	100°	110
			100
			90
18	75	99° (Normal Temp of body)	80
			70
15	65	98°	60
			50
			40
12	55	97°	30
			20
			10

PULSE	
RESP.	
BOWELS	
URINE.	

FLUID BALANCE SHEET

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Patient Name.....

IP No. ..... **Usual Weight** ..... **Kgs.** **Date** .....

INTAKE (in mls)							OUTPUT (in mls)					
				SIGNATURE	ALIMENTARY							URINE
Time	Type	Bottle	Infused		Type	Amount	Vomit	Stool	N/Gast	Others	Urine	Specification Gravity
6-7 AM												
8												
9												
10												
11												
12 MDay												
1 PM												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12 MNight												
1 AM												
2												
3												
4												
5												
6												
Total												

INTRAVENOUS			TOTAL INTAKE		VOMIT	Note: Please record quality of
ALIMENTARY			TOTAL OUTPUT		STOOL	Fluids administered at its conclusion
			TOTAL BALANCE		NASO GAST	Also, how many has been given from
					OTHERS	Present bottle, and how much
					URINE	Drainage fluid by 6 am
TOTAL INTAKE					TOTAL OUTPUT	

OTHER INSTRUCTIONS _____

DISCHARGE SUMMARY

NAME: _____ IP NO: _____WARD: _____

AGE: _____ SEX: _____

DATE OF ADMISSION: _____ DATE OF DISCHARGE: _____

Condition on discharge: ……

Final diagnosis: ……

Operation/Procedures done: ……

History of present illness:

……
……
……
……
……

Investigations:

……
……
……
……

Treatment given:

……
……
……

Discharge medication:

……
……
……
……

Discharge instructions……

……

……

……

T.C.A for review……

Name of Discharging Doctor…… Sign/Stamp: ……

MEDICAL RECORDS EDITING LIST1

All clinical notes should be filled in the following order:

1. Admission & Discharge Protocol
2. Patient Particulars
3. Patient Consent Form
4. Lab Report
5. Admission Form
6. Doctor's Notes
7. Nutrition Notes
8. Treatment Sheet
9. Nursing Care Plan
10. Cardex
11. Temperature & Blood Pressure Chart
12. Fluid Balance Sheet
13. Discharge Summary
14. Charge Sheet
15. NHIF in Patient Claim Form
16. Identity Card Photo Copy
17. Referral Letter
18. Patient Clearance Form

NB. ALL FIELDS ON ALL PAGES MUST BE FILLED

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We Care