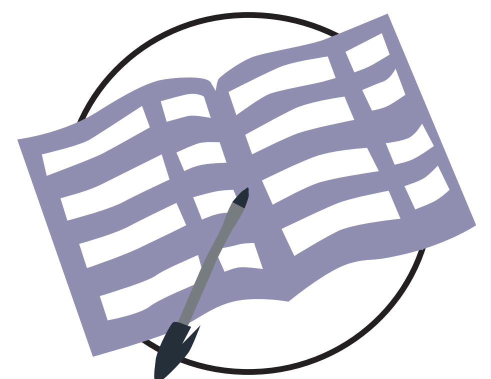
Health Information System

Organisation: ________________

4.0 IPD and Referral

Location: ________________

In-Patient Department (IPD) Register



> Illustrated Guide to IPD Register

A						B		
IPD No.	Name	Age	Sex (M / F)	Status (Ref / Nat)	Address	Date of admission	New or Re-adm.	Diagnosis

A Registration:

IPD No.:
> Enter sequence number in register

Name:
> Print name of patient

Age:
> Enter age (in years)

Sex:
> Enter Male (M) / Female (F)

Status:
> Classify as Refugee (Ref) / National (Nat)

Address:
> Enter Camp Address (Refugee) / Nearest Village (National)

NOTES

It is the responsibility of the staff on each ward to record information neatly and legibly, alongside the individual patient records.

One register book should be available in each IPD ward.

B Visit Details:

Date of visit:
> Enter date (dd/mm/yy)

New or Revisit:
> Classify as New / Revisit (refer to guidelines)

Diagnosis:
> Enter diagnosis. Case definition criteria should be used for reporting purposes only, and not to guide clinical management or treatment.

If more than one diagnosis is made, use a separate row to record each

NOTES

Classification of New and Revisit should meet criteria specified in guidelines (see Module 3: Morbidity).

C

Past history of anti-malarial use †	Blood Smear / Lab results	Treatment	Date of exit	Length of stay (days)	Reason for exit ‡

C

Case Management:

Past history of anti-malarial use:
> For malaria patients who are revisiting for same infection, enter abbreviations to indicate name, dose and duration of prior anti-malarial use

Blood Smear / Lab results:
> Enter result of blood smear for malaria parasite, or other relevant laboratory investigation results as requested

Treatment:
> Enter annotated treatment given. Only include treatment relevant to the diagnosis. For prescribed drugs, enter name, dose and duration.

Date of exit:
> Enter date of exit (dd/mm/yy)

Length of stay:
> Enter number of days between admission and discharge

Reason for exit:
> Enter reason for exit, using options provided in legend at bottom of register page.

Record as Authorized Discharge / Unauthorized Discharge / Death < 24 hours / Death > 24 hours / Referral

NOTES

The IPD Register should include ANNOTATED case information only. Detailed records of history, examination and clinical management should entered in patient notes.

In addition to statistical reporting, IPD Registers serve other important functions:

1. Outbreak Alert
The case-based information collected in the register can play a crucial role in tracing individuals in the event of an outbreak. It is an important reference for the completion of the line listing section within the Outbreak Alert Form (see Module 3: Morbidity; Illustrated Guide to Outbreak Alert Form).

2. Quality of Care
The centralised summary of case-information within each register facilitates acts as a useful monitoring and evaluation tool. Health Managers should periodically audit the books, to review diagnosis and prescription practices in each IPD.

NOTES

Use calendar to calculate length of stay. The number of day is inclusive of both day of admission and day of discharge.

Reasons for exit are listed in a key on each register page. Enter reasons listed in the key ONLY. Repatriation is included within referral as reason for exit.

IPD No.	Name	Age	Sex (M / F)	Status (Ref / Nat)	Address	Date of admission	New or Re-adm.	Diagnosis

† Enter details of previous anti-malarial treatment if relevant (drug name, dose, and duration)

Past history of anti-malarial use †	Blood Smear / Lab results	Treatment	Date of exit	Length of stay (days)	Reason for exit ‡

‡ Reason for exit: 1. Authorized discharge 2. Unauthorized discharge 3. Death (< 24 hours) 4. Death (> 24 hours) 5. Referral