The Catholic University of Eastern Africa

TITLE	AUTHOR
PROCEDURE FOR TREATMENT SERVICES (CUEA/DVC ADM/INF/01)	**SR. IN CHARGE**
	NO. OF APPENDICES:
	3 (THREE) (A-C)

AUTHORIZATION
This Standard Operating Procedure is issued under the authority of:

TITLE	**DVC ADMINISTRATION**
SIGNATURE	
DATE	**23 February 2011**
ISSUE DATE	**23 March 2011**
STAMP CONTROLLED / UNCONTROLLED	CONTROLLED

NOTE:
1. Write amendments on the page provided (Clause 0.2)
2. Controlled copies of this document will be in the DVC Administration and Sr. In Charge's Office

0. CONTENTS AND RECORD OF CHANGES

0.1 Table of Contents

0.2 RECORD OF CHANGES

No.	Date	Details of Changes		Authorization
	(dd-mm-yy)	*Page*	*Clause/subclause*	*Title*
1	19 May 2011	1	3.3(reference KMPPDB)	Sr. In Charge
2	19 May 2011	3	4.2 Definition	Sr. In Charge
3	19 May 2011	3,4 and 5	6.1,6.2,6.5,6.7,6.10-6.19.	Sr. In Charge
4	14 June 2013	7,8,9,10,11	7.0 inclusion of appendices B and C,D,E and F	Sr. In Charge

0.3 Distribution / Circulation

This Standard Operating Procedure is available at relevant function for authorized users

1.0 PURPOSE

To enable the infirmary provide efficient treatment services to its clients.

2.0 SCOPE

It covers all treatment services at the infirmary including all staffs and their dependants, students and patients with Doctors appointment.

3.0 REFERENCES

3.1 University Policies on staff insurance
3.2 Students Handbook

3.3 KMPPDB Regulations
3.4 CUEA Quality Management Manual

4.0 .TERMS AND DEFINITIONS

4.1. **Cue Number** – The number issued to clients on first come first basis to control flow into Clinician/ Doctors room.

4.2 **KMPPDB**_Kenya Medical Practitioners Poisons and Dentistry Board.

5.0 RESPONSIBILITY

The Sister in Charge shall have the overall responsibility to ensure this procedure is adhered to.

6.0 METHOD

6.1. All patients shall be booked in by the receptionist upon production of insurance membership card or students identity card. Their names shall be entered in the Reception Register (CUEA/DVC ADM/INF/01/R01) indicating whether it is an insured or cash paying client.

6.2. The Records Officer shall determine the status of the patient.

6.2.1 If the client is insured the Officer shall retrieve or open a file, issue appointment card, request patient to fill the Insurance Claim Form and shall be ushered into the Clinician/ Doctor's room in line with the cue number.

6.2.2. If the client is cash paying the clerk shall retrieve or open a file, issue appointment card and usher the client into the clinicians/ doctors room in line with the cue number.

6.3. The doctor shall examine the patient with minimum delay and prescribe or send for lab tests or refer appropriately.

6.3.1 If the prescription to pharmacy the doctor shall complete the claim form with the details of treatment given and send the patient to the pharmacy.

6.4 The pharmaceutical technologist shall determine if:

6.4.1 If insured, the pharmaceutical technologist shall dispense the appropriate drugs

6.4.2 If cash paying, the pharmaceutical technologist shall send the patient to clear with

Records Officer before dispensing the appropriate drugs.

6.5 If there is request for lab tests, the doctor shall send the patient to the lab with the filled Lab Request Form (CUEA/DVC ADM/INF/02/fm 01)

6.6 The lab tech shall perform the appropriate tests and forward the results to Records Officer.

6.7 The Records Officer shall forward the results to the doctor.

6.8. The doctor shall review the results and treat the patient.

6.9. If referral, the doctor shall fill the appropriate referral form and direct the patient to the service provider.

6.10. The Doctor shall fill Referral Form (CUEA/DVC ADM/INF/01/fm 01) for referrals for further management.

6.11. The Doctor shall fill Radiology Request Form (CUEA/DVC ADM/INF/01/fm 02) for X-Ray and scan tests.

6.12. The Doctor shall fill Sick Off Form (CUEA/DVC ADM/INF/01/fm 06) for patients, in the Doctor's opinion, unable to attend their daily duties and requiring rest.

MEDICAL EXAMINATION:

6.14. These shall be carried out in fulfilment of the requirement for employment, education and food handlers in the Catholic University of Eastern Africa.

6.15. The Doctors shall complete Medical Examination Form (CUEA/ DVC ADM/INF/01/fm 03) for clients for employment purposes.

6.16. The Doctor shall complete Medical Examination Form (CUEA/DVC ADM/INF/01/fm 04) for food handlers evaluation.

6.17. The Doctor's shall complete Medical Examination Form (CUEA/DVC ADM/INF/01/fm 05) for clients for further education.

CLIENT FEED BACK

6.18. There shall be a client feedback box placed at the reception for of the Infirmary. Client feedback form (CUEA/DVC ADM/01/fm 07 shall be availed at the reception for clients to give

their feedback on the services they have received at the Infirmary. The information shall be analyzed to help improve the services provided.

7.0. APPENDICES

7.1. Appendix A: Process Map

7.2. Appendix B: Referral form.

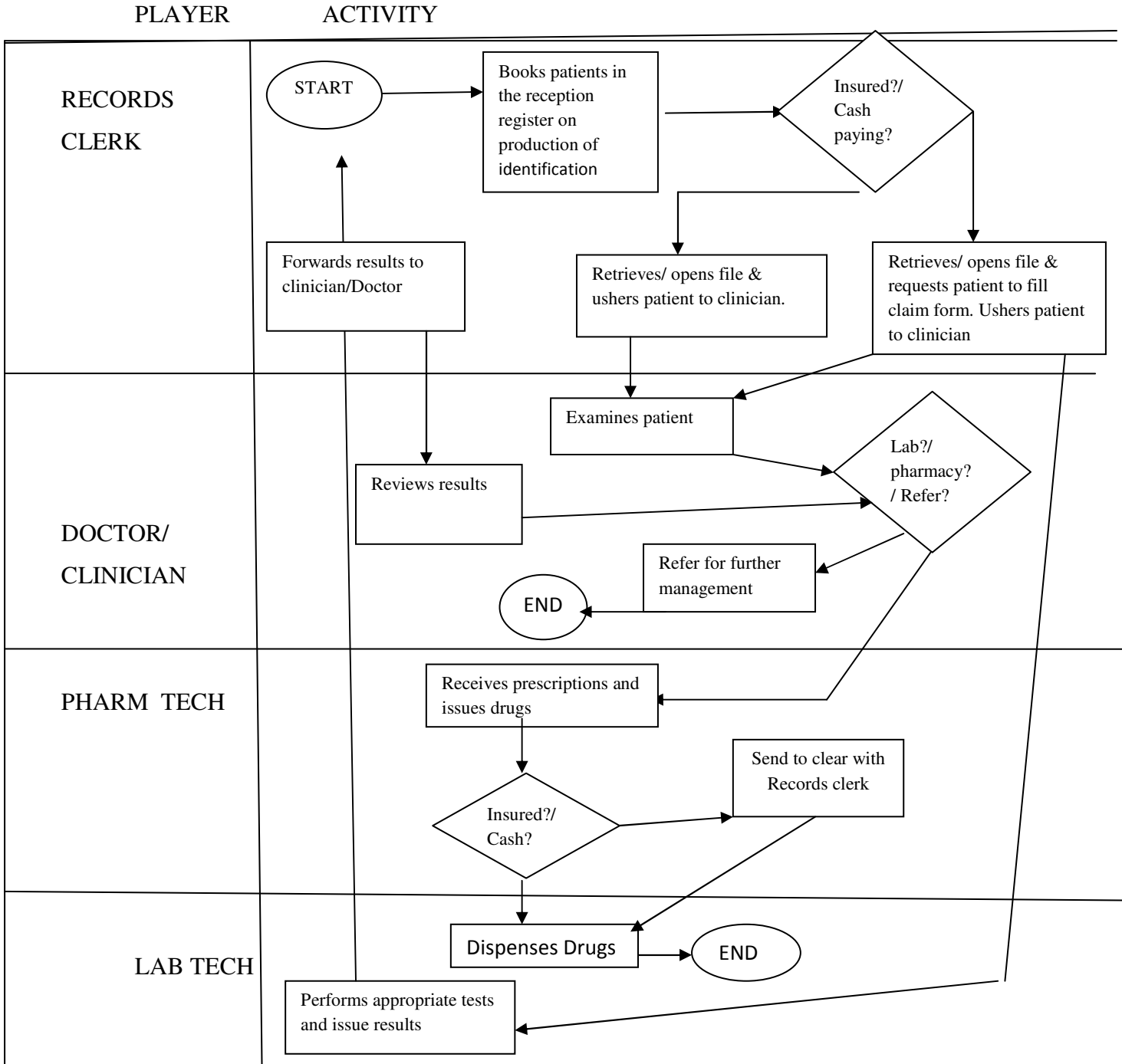
7.3. Appendix C: Radiology Form.

7.4. Appendix D: Lab Request Form

7.5. Appendix E: Referral Form

7.6. Appendix F: Sick Off

Appendix A: **Process Map**



Appendix B: Referral form.

THE CATHOLIC UNIVERSITY OF EASTERN AFRICA

A. M. E. C. E. A

P.O. Box 62157
Nairobi - KENYA
Telephone: 891601-6
Fax: 254-20-891084

Infirmary

REFERRAL FORM:

Name of Patient:_____

Age:_____ ***Sex***_____ ***Date:*** _____

Reasons for Referral:_____

_____

_____

_____

_____

Treatment Given:_____

_____

_____

_____

_____

Name of Doctor: _____

Signature: _____

CUEA/DVC ADM/INF/01/fm01

Appendix C: Radiology Form.

THE CATHOLIC UNIVERSITY OF EASTERN AFRICA
A. M. E. C. E. A

P.O. Box 62157
Nairobi - KENYA
Telephone: 891601-6
Fax: 254-20-891084

Infirmary

RADIOLOGY FORM

Name of Patient:_____

Age: _____***Sex:*** _____***Date:***_____

Clinical History and Diagnosis / Medication: _____

_____

_____***EXAMINATION REQUIRED:***

X-RAY: _____

_____

_____

ULTRASOUND _____

_____

C.T.SCAN: _____

_____

_____

MRI: _____

_____

_____

Name of Doctor: _____

Signature: _____

CUEA DVC ADM/INF/01/fm02.

Appendix D: Lab Request Form

THE CATHOLIC UNIVERSITY OF EASTERN AFRICA

A. M. E. C. E. A

Infirmary

P.O. Box 62157
Nairobi - KENYA
Telephone: 891601-6
Fax: 254-20-891084

LABORATORY REQUEST FORM

PATIENTS NAME:_____ AGE:_____ SEX:_____

REF. DR._____ DATE: _____

BRIEF CLINICAL/ MEDICAL HISTORY:_____

_____

_____

SPECIMEN(S):_____

TEST(S):_____

LAB REPORT:

LAB NO._____ **DATE COLLE/EXAM**_____**TIME**_____ **TECH SIGN**_____

Appendix E: Referral Form

THE CATHOLIC UNIVERSITY OF EASTERN AFRICA

A. M. E. C. E. A

Infirmary

P.O. Box 62157
Nairobi - KENYA
Telephone: 891601-6
Fax: 254-20-891084

REFERRAL FORM:

Name of Patient:_____

Age:_____ ***Sex***_____ ***Date:*** _____

Reasons for Referral:_____

_____

_____

_____

_____

_____

Treatment Given:_____

_____

_____

_____

_____

_____

Name of Doctor: _____

Signature: _____

CUEA/DVC ADM/INF/01/fm01

Appendix F: Sick Off

Infirmary

P.O. Box 62157
Nairobi - KENYA
Telephone: 891601-6
Fax: 254-20-891084

SICK OFF FORM

NAME OF THE PATIENT: _____

AGE: _____ ***SEX:*** _____ ***DATE:*** _____

The above named patient is unwell and on medication. He/ She has been granted a sick off as from _____ *to* _____

DOCTOR'S NAME: _____

SIGNATURE: _____

CUEA/DVC ADM/INF/01/fm06.