

Policy Title: Management of patient in the first visit

Department/Unite:
General Clinics.

Policy Number:
UOJ-MSA-GC-P/01

Replaces No:

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Effective Date:

Review Date:

Revision History

Subject	Changes made	Done by	Revision date

1. **CONDITIONS:** 1.1 All staff of General Clinics.
2. **PURPOSE:** 2.1 This policy contains guidelines on how the physician could perform comprehensive history taking and physical examination and requesting proper laboratory investigations on the first visit of the patient to the general clinic.
3. **DEFINITIONS:** 3.1 The first visit is the first visit to the general clinic by the patient through which comprehensive history and clinical examination and investigation of the patient conducted and documented in the patient's medical record.
4. **Related Documents:** N/A
5. **POLICY:** 5.1 The policy of the MSA during the first visit of the patient to the general clinic is to perform:
- 5.1.1 comprehensive history taking and clinical examination and proper laboratory investigations of the patient in his first visit to general clinic.
- 5.1.2 proper documentation of the whole visit contents in the patient's electronic medical record.

6. PROCEDURES:

6.1 Once the patient enters the MSA, the patient will follow the prescribed path from the reception and the health records and then the triage station where the patients are sorted into one of the following cases:

6.1.1. An emergency patient is sent directly to the emergency room.

6.1.2. A patient whose condition is stable follows one of the following options:

6.1.2.1. If the visit is a follow-up date, the patient's vital signs will be taken and referred to specialist clinics (such as the Chronic Diseases Clinic, the Healthy Child Clinic, the Pregnant Care Clinic, and the Family Medicine Clinic when receiving a follow-up appointment).

6.1.2.2. If the visit is without a follow-up appointment, the patient is referred to the nursing station and using the nursing assessment form, he / she has the early nursing examination and the vital signs, and the physical measurements are taken and he / she is referred to the family medicine clinic.

6.2 The physician should review the data recorded in the nursing assessment form, complete the early detection process using the physician's evaluation form, take the appropriate medical and family history, examine the appropriate clinical examination, and request the routine laboratory tests he / she needs.

6.3. The physician should report in the patient's medical record any allergic history or any history of previous surgical procedures been done to the patient

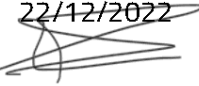
6.4. The physician and nurse in the general clinic should deliver properly the health education topics needed by the patient during the visit

6.5. The doctor of the Family Medicine Clinic or the General Clinic performs a periodic health evaluation by applying the age-specific form and containing the procedures for each age group

6.6. All the findings of the patients medical and family history and clinical examination and investigations requested and health educations topics delivered during the visit should be properly documented in the patient's electronic medical record by the physician and nurse.

7. **RESPONSIBILITIES**
- 7.1 The team working in the general clinic should ensure the compliance to this policy and procedure.
- 7.2 The physician is required to take properly the patient history and perform the clinical examination and document these in patient`s electronic medical record.
- 7.3 The nurse is required to receive the patient`s medical record and to take the vital signs and prepare the patient for examination.
8. **Appendix:**
- 8.1 Referral form
- 8.2 Communicable disease notification form
- 8.3 Medical report form
- 8.4 Patient pass way flowchart
- 8.5 Nurse assessment form
- 8.6 Doctor assessment form
- 8.7 Periodic Examination forms for different age groups
9. **REFERRANCES:**
- 9.1 Ministry of Health Manual for general clinic.



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