

**THE UNITED REPUBLIC OF TANZANIA**

**MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN**

**DIVISION OF NURSING AND MIDWIFERY SERVICES**

**NURSING SERVICES FORMS**

**OCTOBER, 2020**

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Ministry of Health, Community Development, Gender,

Elderly and Children, July 2020,

Government City – Mtumba,

Afya Road,

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40478 DODOMA.

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# **FOREWORD**

The Division of Nursing and Midwifery Services (DNMS) under the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC), has the role to oversee the provision of quality Nursing and Midwifery services in the country. One of its responsibilities is to develop monitoring tools for clinical practice and review protocols for appropriate service provision according to strategies, policy guidelines, and standards to ensure the smooth running of clinical services.

Nursing documentation is a critical component of nursing practice as well as essential for effective communication across disciplines. Appropriate documentation provides an accurate reflection of nursing assessments, care provided, and patient information to support the multidisciplinary team to deliver great and quality patient care. Nursing documentation forms are needed to ensure that the continuity, safety, and quality of care endure across the multiple handovers made by the various health care provider involved in a patient’s care.

In Tanzania Nursing services documentation tool are not standardized, as result each facility designed its own tool for documentation of Nursing services, this pauses a lot of challenges in evaluating patient care rendered. To ensure uniformity in the documentation of the nursing services, the MoHCDGEC through DNMS developed a total of fourteen (14) standardized forms as well as the Standard Operating Procedures (SOPs) for instructing users on proper ways of filling these forms.

These forms will be operationalized by DNMS at all levels and it is anticipated that Nursing and Midwifery workforce and other health care providers in this country will find these Nursing forms useful and effective in delivering quality care to meet public health needs and expectations.

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Prof. Abel N. Makubi

**Chief Medical Officer**

# ACKNOWLEDGMENT

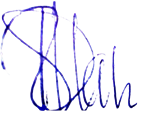
The Division of Nursing and Midwifery Services acknowledge the support from MoHCDGEC Management, health institutions, and individuals for making development of Nursing services documentation forms a success.

Sincere appreciation is extended to Anna Mussa IPD Manager Amana Hospital, Lalbella Mbelwa DNO Kibaha DC, Redempta Matindi DNS and Patrick Emmanuel NO from MAMC Ubungo, Marwa W. Obogo EMD Manager MNH, Musa Wambura NOI Mwanyamala RRH, Francis Itima OPD Manager Amana Hospital, Valentina Msechu DNS Kairuki Hospital, Msafiri Sehaba DNS Tumbi Hospital, Erasto Kalinga from MNH, Segulina Ogonga from Mwananyamala RRH, Stella Eramba from Temeke RRH and Adelaide Emmanuel Secretary from MoHCDGEC.

The Division is extremely grateful for the diligent work of coordinating all the deeds regarding the development of Nursing forms from the MoHCDGEC team; Gustav Moyo, Jamila Hamudu, Saturini Manangwa, Veronica Mpazi, Salome Mwenjuma, Machimu Venance, Wingod Matowo, Simon Nzilibili, Edwin Damas, and Happiness Kabululu.

Heartfelt appreciations to the Nursing Officer In-charges from all 28 Regional Referral Hospitals, and the Director of Nursing Services, Agakhan Hospital, for their constructive comments and contributions in the development of these forms.

Finally, the division express the special thanks of gratitude to all DNMS staff who fully participated tirelessly throughout the process of harmonizing and standardizing the Nursing services forms.



Ziada. J. Sellah

**Director,**

**Division of Nursing and Midwifery Services**

# **ABBREVIATIONS**

|  |  |
| --- | --- |
| ABG | Arterial Blood Gas |
| AVPU | Alert, Verbal, Pain, Unresponsive |
| B/S | Blood Slide |
| BP | Blood Pressure |
| C/S | Caesarean Section |
| CBP | Complete Blood Picture |
| CCP | Cyclic Citrullinated Peptide |
| CG4 | Complementation Group 4 |
| COPD | Chronic Obstructive Pulmonary Disorder |
| CT SCAN | Computed Tomography Scan |
| CV | Cardiovascular |
| D10 | Dextrose 10% |
| D5 | Dextrose 5% |
| DAMA | Discharge Against Medical Advice |
| DNS | Dextrose/Sodium Chloride Solution |
| DNS | Director of Nursing Services |
| DOA | Date of Admission |
| DOD | Date of Death |
| ECG | Echo Cardiogram |
| EMD | Emergency Medicine Department |
| FAST US | Fast Ultra Sound |
| FBP | Full Blood Picture |
| FSB | Fresh Stillbirth |
| HIV/AIDS | Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome |
| IV | Intra Venous |
| LNMP | Last Normal Menstrual Period |
| MRDT | Malaria Rapid Diagnostic Test |
| MSB | Macerated Stillbirth |
| NS | Normal Saline |
| PR | Pulse Rate |
| RBG | Random Blood Glucose |
| RL | Ringers Lactate |
| RR | Respiratory Rate |
| SPO₂ | Saturation Pressure Of Oxygen |
| SVD | Spontaneous Vaginal Delivery |
| TEMP | Temperature |
| UPT | Urine Pregnancy Test |

# EXECUTIVE SUMMARY

Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice. Nurses practice across different settings from bedside to the administrative office hence are responsible and accountable for the nursing documentation which is the primary source of evidence used to continuously measure performance outcomes against predetermined standards, of individual nurses and health care team members

Nurses document their work and outcomes for several reasons: the most important is for communicating within the health care team and providing information for other professionals in legal, legislative, reimbursement, research, and quality activities/services.

High-quality documentation, however, is a necessary and integral aspect of the work of registered nurses in all roles and settings. This requires providing nurses with sufficient time and resources to support documentation activities.

Standardization of the nursing forms within concurrence documentation of the nursing services delivered to patients has been done and a total of fourteen (14) forms and Standard Operating Procedures to help filling these forms were developed. These forms are; Nursing Care Plan Form, Observation Chart, Medication Chart, Nursing Round Form, Ward Round Form, Pediatric Observation Chart, Consent Form, *Fomu Ya Ridhaa*, Supervisor’s Report Form, Nursing Handling Over Form, Pre-Operative Checklist, Emergency Form, Referral Form, and Last Office Form.

These forms will be used by all health facilities from National to Dispensary level of public, private and faith-based facilities as the primary source of evidence to continuously measure performance outcomes against predetermined standards, of individual nurses or health care team members, as a result, to simplify monitoring and evaluation of health services planning and decision making.

# FORM NO. 1: NURSING CARE PLAN.

This is a form designed to document nursing services given to patients. Information filled are delivered from the nursing process. Nursing process is a systematic method of providing nursing care to clients. The purpose of conducting nursing process includes identification of clients’ health problems (subjective and objective), to establish plans to meet the identified needs and to deliver specific nursing interventions.

Nurses are obliged to use Nursing process to fill this form for all inpatients in the hospital.

**INSTRUCTIONS ON FILLING NURSING CARE PLAN FORM**.

1. Fill the name and address of the health facility.
2. Fill the patient’s particulars in capital letter:(ask name from the patients /relative, check from the patient’s file).
3. Fill the date of admission and the medical diagnosis as per the patient’s file.
4. Obtain and document subjective and objective data through history taking and physical examination.
5. Nursing diagnoses may be actual or potential.
6. The actual diagnosis must include problem, etiology, signs and symptoms.
7. The potential diagnosis must include risk and related factors.
8. Before planning the Nursing care, perform a thorough assessment to identify patient’s problems.
9. The patient’s problems identified must be arranged in priority order.
10. One Nursing diagnosis might have more than one intervention.
11. All the implemented activities should be evaluated timely and separately.
12. Evaluation of patient’s care must include time evaluation was made.
13. Make sure that ALL the columns are completely and accurately filled.
14. The filled nursing care plan form must be kept in the patient’s file.
15. The provider’s initials must be used to represent the provider’s names.

**FORM NO. 1**

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| UNITED REPUBLIC OF TANZANIA  MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN  C:\Users\LENOVO\AppData\Local\Temp\ksohtml12476\wps2.png  NAME AND ADDRESS OF HEALTH FACILITY  …………………………………………………………………………… | **NURSING CARE PLAN**  Hospital Reg. Number…………………………………………………  Surname……………………………………First Name.……………………………… Middle Name ………………………………Age………… Sex…….M / F Ward/Unit.………………………………………………………………….. |
| Date of Admission (Date………Month………Year……………) Medical Diagnosis…………………………………………………………………………  Patient’s problems; I. Objective data………………………………………………………………………………………………………………………………..  II. Subjective data………………………………………………………………………………………………………………………………   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Date** | **Time** | **Nursing Diagnosis** | **Expected outcome** | **Implementation/Interventions** | **Evaluation** | **Provider’s Name** | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Date** | **Time** | **Nursing Diagnosis** | **Expected outcome** | **Implementation/Interventions** | **Evaluation** | **Provider’s Name** | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | | |

**Nursing Services Forms Version 1**

# FORM NO. 2: PATIENT OBSERVATION CHART.

Observation charts are used by clinical teams to record the patient’s physiological parameters: respiratory rate, oxygen saturation levels, blood pressure, temperature, pulse rate, and level of consciousness. Early warning scores are derived from these parameters and are used to alert members of the team to deterioration of a patient’s condition and indicate the most appropriate escalation of care. This form should be used for all patients.

**INSTRUCTIONS ON FILLING PATIENT OBSERVATION CHART.**

1. This form must be filled to all patients.
2. It must be filled at the beginning of a shift, admission, discharge, during rounds, when needed.
3. Fill the patient’s particulars (ask patients/relatives, check the patient’s file).
4. Particulars should be in capital letters.
5. On the item of sex put M for male and F for female.
6. Height will be checked once during admission or attending to Out Patient Department (OPD).
7. Weight and RBG will be taken during admission and when necessary.
8. Vital signs include SPO₂ must be taken at least once during each shift and whenever necessary.
9. On the parameter of bowel opening put Y if there is bowel opening and N if bowel opening is absent.
10. On positioning the patient, the abbreviations have the following meaning LL - Left lateral, RL - Right Lateral, SUP – SUPINE, PRON – PRONE, use the initials only.
11. Assess skin status to all bedridden patients per each shift (Put “I for intact, R for redness/signs for loss of skin integrity, B for blisters, and S for sores).
12. Label the name of intravenous fluids with additional medicines, starting and expected end time.
13. Write the amount of intravenous fluid at the starting time, if any interruption happened it must be documented to the space of remark.
14. Use initials to represent the name of the health care provider who attended the patient.

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Date of Admission (Date…... Month….…. Year……….) Medical Diagnosis…………………………….….……………....…………………

**FORM NO 2**

Height …….….. Body Weight……………

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Date** |  | | | |  | | | |  | | | |  | | | |  | | | |
| **Parameters** | **Time** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Temperature OC |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Pulse rate/min |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Resp. rate/min |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| B/P (mmHg) | Systolic |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Diastolic |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| SPO2 (RA/O2) | (%) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| RBG (mmol/L) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Bowel open (stool, flatus) | (Y/N) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Positioning | (LL, RL, SUP, PRON) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Skin Status | (Intact, blister, Red, Sores) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Intake Feeding | NGT/ORAL/TPN |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| I.V Fluids (500,1000mls) | (NS,RL,DNS,D5,D10,OTHERS) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Amount (Mls) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Output in mls | (vomitus, drainage, urine) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Total Intake** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Total output** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Name of Care Provider** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Nursing Services Forms Version 1**

# FORM NO. 3: MEDICATION CHART

A medication chart is a communication tool between nurses and other health professionals regarding patient’s medicines. It is used to direct how and when medicines are to be administered. It may be filled by the health team involved in caring for the patient. All medicines given to patients must be monitored using this tool.

**INSTRUCTIONS ON FILLING MEDICATION CHART:**

1. Fill the patient’s particulars correctly as written in the patient’s file.
2. Particulars should be in capital letters.
3. This chart has two parts; the first part should be filled by the prescriber.
4. The names, designation and signature of the prescriber should be correctly filled.
5. The second part is supposed to be filled by the healthcare provider who administering the medicine to the patient.
6. The types of medicine the patient has should be written vertically (downward) while the frequency of administering the medicine should be written horizontally (right side) of the form.
7. The name of the medicine, time for medication, and the name of the health care provider who administers the medicine must be written at every time medicine is administered.
8. If an additional chart is needed, transfer the patient’s particulars and medicine to the next form.
9. Use generic names of the medicines (for prescribers)
10. Use initials to represent the names of the health care provider who attended the patient.

**FORM NO 3**

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Date of Admission (Date…... Month….…. Year……….) Medical Diagnosis…………………………….….……………....……… Allergy.………………………………………………………………….Weight…….................

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DATE** | **S/No** | **MEDICINE AND ROUTES** | **Prescriber** | | |
| **Names** | **Designation** | **Signature** |
|  |  | ORAL- (Insert Medicine Name, Dosage and Frequency) |  |  |  |
|  | 1A |  |  |  |  |
|  | 2A |  |  |  |  |
|  | 3A |  |  |  |  |
|  | 4A |  |  |  |  |
|  | 5A |  |  |  |  |
|  | 6A |  |  |  |  |
|  | 7A |  |  |  |  |
|  | 8A |  |  |  |  |
|  |  | INJECTION- (Insert Medicine Name, Dosage and Frequency) |  |  |  |
|  | 1B |  |  |  |  |
|  | 2B |  |  |  |  |
|  | 3B |  |  |  |  |
|  | 4B |  |  |  |  |
|  | 5B |  |  |  |  |
|  | 6B |  |  |  |  |
|  | 7B |  |  |  |  |
|  | 8B |  |  |  |  |
|  |  | I.V FLUIDS- (Insert Fluid Name, Volume and Frequency) |  |  |  |
|  | 1C |  |  |  |  |
|  | 2C |  |  |  |  |
|  | 3C |  |  |  |  |
|  | 4C |  |  |  |  |
|  | 5C |  |  |  |  |
|  | 6C |  |  |  |  |
|  | 7C |  |  |  |  |
|  | 8C |  |  |  |  |
|  |  | OTHERS |  |  |  |
|  | 1D |  |  |  |  |
|  | 2D |  |  |  |  |
|  | 3D |  |  |  |  |
|  | 4D |  |  |  |  |
|  | 5D |  |  |  |  |
|  | 6D |  |  |  |  |
|  | 7D |  |  |  |  |
|  | 8D |  |  |  |  |

**Nursing Services Forms Version 1**

Hospital Reg. Number…………………………………Surname……………………………………. First Name.…………...………………………. Middle...……………………………………… Age…...Sex…...M/F Ward/Unit……….……………………………...

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Medicine** | **Time** | **Name** | **Medicine** | **Time** | **Name** | **Medicine** | **Time** | **Name** | **Medicine** | **Time** | **Name** | **Remarks** |
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**Nursing Services Forms Version 1**

Hospital Reg. Number…………………………………Surname……………………………………. First Name.…………...………………………. Middle...……………………………………… Age…...Sex…...M/F Ward/Unit……….……………………………...

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Medicine** | **Time** | **Name** | **Medicine** | **Time** | **Name** | **Medicine** | **Time** | **Name** | **Medicine** | **Time** | **Name** | **Remarks** |
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***Nursing Services Forms Version 1***

# FORM NO. 4: NURSING ROUND FORM.

Nursing round is a procedure in nursing care in which one or more visits to a patient are scheduled by two or more nurses to coordinate care, respond to patient needs, and share insights. An overview of the nursing care of all patients or selected patients is done.

Nursing round should be done every day at 0800 hrs where all nurses must be involved.

**INSTRUCTIONS ON FILLING NURSING ROUND FORM.**

1. The preliminary information should be filled before starting the Nursing round.
2. Enter the particulars of the patient (ask patient/relatives, check the patient’s file).
3. Particulars should be in capital letters.
4. For sex, circle M for male and F for female
5. The patient’s problems should be identified from the assessment done to the selected patient.
6. Care plans should come from problems identified during the assessment of the patient.
7. Agreed decision example consultation, should be filled to the column of remark.
8. Every health care provider involved in the Nursing round should register on part B of this form.
9. A booklet or counter book may be used for facilities that are not using the electronic system.

**FORM NO 4**

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| UNITED REPUBLIC OF TANZANIA  MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN  C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps7.png  NAME OF HEALTH FACILITY  ………………………………………………………………..... | | | | | | **NURSING ROUND FORM**  Date of Nursing Round…...…………………………..  Starting time……….……………… Finishing time…….………………….  Department.....................................Unit/Ward.………….……………  Total patients in the Unit/Ward……………………………  Total patients seen ………………………………………….. | | | | |
| Bed No. | Hosp. Reg. Number | Names of Patient | Sex | Age | DOA | | Diagnosis | Nursing Care Needs | Care Plans | Remarks |
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**Nursing Services Forms Version 1**

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| Names of participants | Designation | Department | Signature | Name of participants | Designation | Department | Signature |
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**ATTENDANCE REGISTER**

**Nursing Services Forms Version 1**

# FORM NO. 5: WARD ROUND FORMS.

Ward round is a regular visit to patients in hospital by medical staff for the purpose of making decisions concerning patient care.

**INSTRUCTIONS ON FILLING WARD ROUND FORM.**

1. The preliminary information should be filled before starting the ward round.
2. Fill the patient’s particulars as they appear in the patient’s file.
3. Planned management should be both medical and nursing management.
4. Action taken is any decision reached for patient care like discharge, referring, feeding, terminating, or shift to next plan.
5. This form may be filled by any health personnel involved in the ward round.
6. Document information of all reviewed patients.
7. The remark should show the prognosis of the patient or any other important information.
8. All care providers involved in the ward round must write their names.
9. Ward round should be done as per the standard of the respective unit.
10. A booklet or counter book may be used instead of facilities that are using a hard copy system.

**FORM NO 5**

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| UNITED REPUBLIC OF TANZANIA  MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN  C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps9.png  NAME OF HEALTH FACILITY  ………………………………………………………………..... | | | | | | **WARD ROUND FORM**  Date of Ward Round…..…………………………..  Starting time………..….……………. Finishing time……….…………………..  Department..................................Unit/Ward.……………………………  Total patients in the Unit/Ward……………Total patients seen ……….. | | | | |
| **Bed No.** | **Hosp. Reg. Number** | **Names of Patient** | **Sex** | **Age** | **DOA** | | **Diagnosis** | **Planned management & Investigations** | **Action taken** | **Remarks** |
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**Nursing Services Forms Version 1**

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**Nursing Services Forms Version 1**

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| **Bed No.** | **Hosp. Reg. Number** | **Names of Patient** | **Sex** | **Age** | **DOA** | **Diagnosis** | **Planned management & Investigation** | **Action taken** | **Remarks** |
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**Nursing Services Forms Version 1**

**ATTENDANCE REGISTER**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Names of Participants | Designation | Department | Signature | Name of Participants | Designation | Department | Signature |
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**Nursing Services Forms Version 1**

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# FORM NO. 6A: CONSENT FORM.

Consent form is a form signed by a patient prior to a medical procedure to confirm that he or she agrees to the procedure and is aware of any risks that might be involved. The purpose of the consent form is to provide evidence that the patient gave consent to the procedure in question.

**INSTRUCTIONS ON FILLING CONSENT FORM.**

1. Fill particulars of the patient (ask name from the patients/relative, check from the patient’s file).
2. The patient’s particulars should be in capital letters.
3. For sex, circle M for male and F for female.
4. The form should be filled by health care providers who will be involved in the procedure.
5. The form must be filled within 24 hours before the procedure.
6. A witness is the nurse who prepared a patient for the procedure.
7. Names of patients, doctor, anesthetist, next of kin, and witness nurse must be filled by a respective person except for patients who are unable to do so, for this case this will be done by other personnel as per directions given on this form.

**FORM NO 6A**

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| UNITED REPUBLIC OF TANZANIA  MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN  C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps11.png  NAME OF HEALTH FACILITY  ………………………………………………………………..... | **INFORMED CONSENT FORM**  Hospital Reg. Number……..….……………………………………………  Surname……………………First Name.…………..……………………….  Middle Name ………………….……..…………..Age………Sex…..M/F  Religion……………….………………Tribe……………….....…………….  Ward/Unit….…………………………………………. |

**THIS CONSENT IS FOR SURGICAL PROCEDURE, DIAGNOSTIC PROCEDURES AND ANAESTHESIA**

1. I ………………………………………………………...……………. (three names), I give consent to Dr. ………………………………… and health team to operate/diagnostic procedure.
2. I have been informed by Dr. ………………………………………………………………. that during the procedure anything may happen as they may find than the one that I was informed before. I give consent to the Doctor and the health team to do the best for my health.
3. I also give consent to be given Anesthesia of any kind, blood transfusion, or its product if needed.
4. I was also informed of the benefits of the procedure, alternatives and possible complications.
5. I ……………………………………………………………………., confirm and declare that I had a clear explanation from the Doctor/Anaesthetist/Anaesthesiologist; I have also read and understood all the explanations above.
6. I have had the opportunity to ask questions and answered clearly. I, therefore, consent for the procedure to be done.

**Nursing Services Forms Version 1**

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| --- | --- | --- | --- | --- | --- | --- |
| **Signatories** | **Names** | **Designation** | **Signature** | **Date** | **Time** | **Phone number** |
| Patient |  |  |  |  |  |  |
| Doctor |  |  |  |  |  |  |
| Anesthetist |  |  |  |  |  |  |
| Next of Kin |  |  |  |  |  |  |
| Witness |  |  |  |  |  |  |

***In the case of an unconscious patient, Minors, Incapable, with no relative consent for operation can be obtained from the Next of Kin, Facility in charge. In case of refusal, a clear signed statement has to be given by the patient.***

**Nursing Services Forms Version 1**

# FOMU NO 6B: FOMU YA RIDHAA.

Fomu ya ridhaa ni kibali ambacho mgonjwa anajaza kabla ya matibabu akithibitisha kuwa amekubali kupatiwa huduma na anajua faida na madhara yanayoweza kujitokeza. Lengo ni kuthibitisha kuwa mgonjwa ameridhia huduma au matibabu hayo.

**MAELEKEZO YA KUJAZA FOMU YA RIDHAA.**

1. Jaza taarifa za mgonjwa kwenye fomu hii kama zilivyo katika jalada la mgonjwa.
2. Taarifa za mgonjwa ziandikwe kwa herufi kubwa.
3. Sehemu ya jinsia zungushia ME kwa mwanaume na KE kwa mwanamke.
4. Fomu ijazwe na mtalaamu atakayehusika kumpatia mgonjwa huduma.
5. Fomu ijazwe ndani ya masaa 24 kabla ya huduma kutolewa.
6. Shahidi ni muuguzi aliemuandaa mgonjwa.
7. Mgonjwa, daktari, mtalaamu wa dawa ya ganzi, ndugu wa karibu na shahidi lazima wajaze majina yao wenyewe isipokua kwa mgonjwa ambaye hajiwezi ajaziwe na kiongozi kama fomu inavyoelekeza.

**FORM NO 6B**

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| JAMHURI YA MUUNGANO WA TANZANIA  WIZARA YA AFYA, MAENDELEO YA JAMII, JINSIA, WAZEE NA WATOTO  C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps14.png  JINA LA KITUO/HOSPITALI  ……………………………………………………………… | **KIBALI CHA RIDHAA YA MATIBABU**  Namba ya Usajili……..….………………………..……………….............  Jina la Ukoo ……………………………Jina la Kwanza………..…………. Jina la Kati …………………….……..…….Umri……. Jinsi…..…ME/KE  Dini……………...…………………………….Kabila………….....……………  Wodi/Kitengo…………..……………………………………………………… |

**FOMU YA IDHINI YA KUFANYIWA UPASUAJI, UCHUNGUZI NA KUPEWA DAWA YA GANZI**

1. Mimi………………………………………………………… (majina matatu) ninamruhusu Daktari …………………………………………. na jopo la wataalam wengine watakaoshiriki katika kufanya huduma ya upasuaji/uchunguzi wa ……………………… ………………………………………………………………. jina la upasuaji/uchunguzi ……………………………
2. Nimeelezwa na Daktari………………………………………………., kwamba wakati wa upasuaji endapo daktari atagundua matatizo mengine ambayo hayakugundulika kabla, ninamruhusu Daktari na jopo la Wataalam kufanya upasuaji kadiri watakavyoona inafaa kwa ajili ya usitawi wa afya yangu.
3. Naidhinisha pia kupewa dawa, ganzi, au kuongezewa damu kadiri itakavyohitajika kwa njia zozote kutokana na uamuzi wa wataalamu.
4. Nimeelezwa pia juu ya faida za kufanyiwa upasuaji/uchunguzi na njia mbadala za matibabu na madhara yanayoweza kujitokeza kwa kufanyiwa ama kutokufanyiwa huduma hii.
5. Mimi…………………………………………., nathibitisha kuwa nimeelezwa, nimesoma na kuelewa maelekezo yote hapo juu
6. Nilipata wasaa wa kuuliza na kujibiwa maswali yangu kwa ufasaha. Hivyo, naridhia kufanyiwa upasuaji/uchunguzi kama ilivyopangwa.

***Nursing Services Forms Version 1***

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| **Watia Saini** | **Jina** | **Cheo** | **Saini** | **Tarehe** | **Muda** | **Namba ya Simu** |
| Mgonjwa |  |  |  |  |  |  |
| Daktari |  |  |  |  |  |  |
| Mtaalam wa dawa ya ganzi |  |  |  |  |  |  |
| Ndugu wa karibu |  |  |  |  |  |  |
| Shahidi |  |  |  |  |  |  |

***Endapo mgonjwa hana uwezo wa kutoa idhini kutokana na hali yake (Wagonjwa Mahututi, Watoto chini ya Miaka 18, Wagonjwa Wasiojiweza, Wasio na Wazazi/Walezi), Ndugu wa karibu au Mkuu wa Kituo anaweza kutoa idhini kwa niaba yake akizingatia kuwa uamuzi anaotoa una manufaa kwa mgonjwa.***

**Nursing Services Forms Version 1**

# FORM NO. 7: PEDIATRIC OBSERVATION CHART.

This is an observation chart specific to pediatrics. It is used by health care providers to record a pediatrics’ physiological parameters that alert them on the status of the child and make appropriate decisions of care.

**INSTRUCTIONS ON FILLING PEDIATRIC OBSERVATION CHART**.

1. Fill particulars of the patient (ask names from the patients/relative, check from the patient’s file).
2. Record the date of birth accordingly.
3. Particulars should be in capital letters.
4. For sex, circle M for male and F for female.
5. Height will be checked during admission and every month.
6. Weight, head circumference and upper arm circumference will be checked once during admission and daily.
7. RBG should be checked during admission and monitored depends on the status.
8. Vital signs include SPO₂ must be taken at least once at each shift (depends on patient’s status).
9. For Visual Intravenous Phlebitis VIP score, put;

* 0 if no signs of phlebitis
* 1 if there is pain at IV site (possible phlebitis)
* 2 if there is pain erythematic + swelling (early stage)
* 3 if there is pain along pathway of cannular medium stage
* 4 if there is pain, palpable venous cord, (advanced stage )
* 5 if there is pain, pyrexia, induration, palpable venous cord(very advanced stage).

1. Label the name of intravenous fluids with additional medicines, starting and expected end time
2. Write the amount of intravenous fluid at the starting time of titration, if any interruption of running fluid happens it must be documented to the space of remark.
3. Feedings; put 1 for water, 2 for ORS, 3 for milk, 4 for soft porridge and 5 for others.
4. For feeding routes; put O for oral, N for Nasal Gastric Tube (NGT) and T for Total Parenteral Nutrition (TPN).
5. Write the amount of oral fluids given immediately after feeding.
6. Put V if the patient has vomited, observe color and smell of the vomitus and document the approximated amount.
7. Urine output; for pediatrics with no indwelling catheter, weigh the pampers before worn the child and then weigh it after undress.
8. Stool; Ask whether the child has passed stool and its appearance. Put B for brown, Y for yellow, B for black, R for bloody, and A for other abnormal stool.
9. Fluid balance, total fluid input, and output will be calculated after 24 hours.
10. Use initials to represent the name of the health care provider who attended the patient.

**FORM NO 7**

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| UNITED REPUBLIC OF TANZANIA  MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN  C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps15.png  NAME OF HEALTH FACILITY  ……………………………………………………….. | **PEDIATRIC OBSERVATION CHART**  Hospital Reg. Number……..……..………………………..........................................  Surname…………………………………….First Name.………………………………………… Middle Name ………………………..Date of Birth (Date……..Month.......Year……..  Sex……M/F Ward/Unit………..………… |

Date of Admission (Date…... Month….…. Year……….) Time …………… Medical Diagnosis…………………………………………………

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date/Month |  | | | |  | | | |  | | | |  | | | |
| Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Height (cm) |  | | | |  | | | |  | | | |  | | | |
| Weight (kg) |  | | | |  | | | |  | | | |  | | | |
| Head Circumference (cm) |  | | | |  | | | |  | | | |  | | | |
| Upper arm circumference (cm) |  | | | |  | | | |  | | | |  | | | |
| Temperature (Celsius) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Pulse rate (B/minute) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Respiratory rate (cycles/minute) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| SPO2% |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Blood Pressure (Mm Hg |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| RBG (mmol/L) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Nursing Services Forms Version 1**

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| Visual Intravenous Phlebitis (Put 0, 1, 2, 3, 4, 5) | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| IV fluids | Type (NS, RL, DNS, D5, D10, Others) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Amount (mls) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Feedings/Fluids | Type (1. water, 2. ORS, 3. milk, 4. uji, 5. others) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Route (Oral, NGT, TPN) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Amount (mls) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Vomitus (put tick) | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Urine output (mls) | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Stool | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Fluid balance | Total input |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Total output |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| INITIALS OF SERVICE PROVIDER | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Nursing Services Forms Version 1**

# FORM NO. 8: PRE-OPERATIVE CHECKLIST

This form consists of a number of issues that have to be done to the patient before operation. The health care provider will use this to see if all have been met as part of ensuring the safety of the patient. Assessment of requirements needed before operation help to detect difficulties or problems which can endanger the patient’s life or the expected result of the surgery.

**INSTRUCTIONS ON FILLING OF PRE-OPERATIVE CHECKLIST.**

1. Fill the name and address of the health facility.
2. Fill the patient’s particulars (ask patients/relatives, check the patient’s file).
3. Particulars should be in capital letter
4. Put Y in the YES column if the items have been done, or put N in the NO column if the items have not been done and NA for items which are not applicable. (For all items with N make follow up).
5. On item number 23, write down if there is any special information obtained.
6. Names, designation and signature of the care providers who filled the checklist, escorted the patient to the operating theatre and received the patient at the operating theatre should be written.

**FORM NO 8**

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| UNITED REPUBLIC OF TANZANIA  MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN  C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps17.png  NAME OF HEALTH FACILITY  ……………………………………………………… | **PRE-OPERATIVE CHECKLIST**  Hospital Reg. Number……...….…………………………………………………...  Surname……………………………………First Name.……………….…………. Middle Name ………………….……...………………Age……...Sex………M/F  Religion………………….……………………. Tribe………….......…………….  Ward/Unit….………........................... |

Date of Admission (Date…....... Month….……. Year……….) Medical Diagnosis……………………………………....………………………

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **No.** | **Contents** | **YES** | **NO** | **NA** |
| 1 | Right Patient for right procedure verification (Verify on file and bands; three names of patients, registration number, age, sex, procedure to be done) |  |  |  |
| 2 | Consent form signed – Countercheck / confirm whether the signed consent form - is well understood |  |  |  |
| 3 | Vital signs were taken immediately before brought to Theater |  |  |  |
| 4 | Blood grouping and cross-matching results are available |  |  |  |
| 5 | Hemoglobin level is known/results |  |  |  |
| 6 | Pre-operative medication given |  |  |  |
| 7 | Fasting time |  |  |  |
| 8 | Pre-operative skin preparation? (body hygiene) |  |  |  |
| 9 | The operative site marked? with color or Draper |  |  |  |
| 10 | Loose teeth |  |  |  |
| 11 | Dentures, crowns and bridges removed |  |  |  |

**Nursing Services Forms Version 1**

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| --- | --- | --- | --- | --- | --- |
| 12 | Any prosthesis | |  |  |  |
| 13 | Jewelry removed and rings tapped (If cannot be removed easily) | |  |  |  |
| 14 | Patient’s valuables secured | |  |  |  |
| 15 | Cosmetics and clothing removed ( Nail polish as we have to observe cyanosis | |  |  |  |
| 16 | Case notes accompanied by patient | |  |  |  |
| 17 | Investigative reports e.g. Radiological reports accompanied with patient | |  |  |  |
| 18 | Any allergic reaction reported | |  |  |  |
| 19 | Last urine voiding time recorded | |  |  |  |
| 20 | Bowel opened | |  |  |  |
| 21 | Bowel cleared | |  |  |  |
| 22 | Checklist completed | |  |  |  |
| 23 | Special Information (if any)………………………………….…………………………………………… | |  |  |  |
| 24 | Checklist done by; Name…………………………………………………..Designation……………….Signature……………………… | | | | |
| 25 | Patient escorted by ………...…………………………………………  Designation ....…………………………………………………………  Signature…………………………time………………………………... | Patient received by ……………………………………………….. Designation .........………………………………………………….  Signature………………………time……………………………….. | | | |

**Nursing Services Forms Version 1**

# FORM NO. 9: SUPERVISORS’ REPORT FORM.

This form should be used by hospital supervisors to record vital information about the hospital. A nursesupervisor is responsible for managing staff, overseeing patients care and ensuring adherence to established policies, guidelines, and procedures. The nurse supervisor also acts as a link between staff, patients, patients' families, and hospital management.

**INSTRUCTIONS ON FILLING SUPERVISOR’S REPORT FORM.**

1. Fill the name and address of the health facility.
2. Date, time and respective shift should be filled accordingly.
3. The description of serious patients must be well documented.
4. Hospital reports should be written clearly.
5. All the columns and rows should be completely filled.
6. The names and signatures of the nurse who is handing over and receiving the report must be written.
7. Hospital bed state should be clearly stated (match with those from the unit or wards).
8. A booklet or counter book may be used instead of facilities that are using a hard copy system.

**FORM NO 9**

UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN



NAME OF HEALTH FACILITY

……………………………………………….…………..............

**SUPERVISOR’S HOSPITAL REPORT FORM**

Date……………………….……………. Time…………………….…………………. Shift (Morning, Evening, Night) ……………………………………

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Description of serious patient** | | | | | | | | | | |
| **DOA** | **Ward** | **Bed No.** | **Reg.No** | **Names of patients** | **Age** | **Sex** | **Diagnosis** | **GCS** | **Medical and Nursing management given** | **Pending issues** |
|  |  |  |  |  |  |  |  |  |  |  |
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**Nursing Services Forms Version 1**

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| **Description of Hospital Report and Bed State** | | | | | | | | | | | | | | | | | |
| **Ward** | **Prev. No of patients** | **New Admission** | **Present No. of Patients** | **Discharge** | **Transfer in** | **Transfer out** | **Referral received** | **Referral Out** | **Absconded** | **DAMA** | **Death** | **Surgeries** | | **Number of Staff on Duty** | | | |
| **Major** | **Minor** | **RN** | **EN** | **DR** | **ATT** |
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| **To** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Nursing Services Forms Version 1**

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| **Key Info** | **SVD** | **C/S** | **FSB** | **MSB** | **Low scores** | **Neonatal deaths** | **Total Deliveries** | **Maternal deaths** | **Status of Ambulance** | **Availability of water** | **Availability of electricity** | **Staff of call responded** | **Official visitors** |
| **No./Status** |  |  |  |  |  |  |  |  |  |  |  |  |  |

Any other event/incidence to report…………………………………………………………………………………………………………………………………….

Name of the Reporting Supervisor……………………………………………………Name of the Receiving supervisor…………………………………

# FORM NO. 10: HANDING OVER SHIFT REPORT FORM.

A nursing handover occurs when one nurse hands over the responsibility of care for a patient to another nurse. This should be done at the end of a nursing shift. On average, nursing handovers occur three times a day i.e. morning, evening and night shift.

**INSTRUCTIONS ON FILLING HANDING OVER SHIFT REPORT FORM.**

1. Fill the name and address of the health facility.
2. Date, time, department, ward and respective shift should be filled correctly.
3. Description of serious patients must be well documented
4. Medical equipment and medicines must be handed over physically.
5. All columns on the summary information for the ward status should be accurately filled by the shift in charge.
6. Names and signatures of nurses who are handing over and receiving the shift must be well written.
7. A booklet or counter book may be used instead for facilities who are using a hard copy system.

**FORM NO 10**

UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN



NAME OF HEALTH FACILITY

……………………………………………….…………..............

**NURSING SHIFT HANDING OVER REPORT FORM**

Date……………....……Time……….… Department……………………………….………Ward………………...……………………...………………..

Shift (Morning, Evening, Night) ………………………………………………….

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Description of serious patient** | | | | | | | | | | **Items handled** |
| **BedNo.** | **DOA** | **Name** | **RegNo.** | **Age** | **Sex** | **Diagnosis** | **GCS** | **Nursing Care Given** | **Pending Care Issues** | **Eg., Thermometer, Dangerous drugs, emergency drugs, etc.** |
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**Nursing Services Forms Version 1**

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| **Summary for Ward status per shift (to be filled by shift In charge )** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Number of previous patients** | **Admission** | **Discharge** | **Transfer** | | **Referral** | | **Absconded** | **DAMA** | **No. of present patients** | **Total Deliveries** | **Pre-op Patients** | **Surgeries** | | **Post-op patients** | **Death** | **Total staff** | |
| **IN** | **OUT** | **Received** | **Out** | **Major** | **Minor** | **Nurses** | **H/Ass** |
|  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |

Any other event/incidence to report……………………………………………………………………………………………………………………

Reported by…………………………………………………………………………..Signature….…………………………………………………….…

Received by……………………………..……………………………………………Signature…………………………………………………………..

**Nursing Services Forms Version 1**

# FORM NO. 11: EMERGENCY CARE FORM.

This form will be used to record care rendered to patients in emergency or OPD units.

**INSTRUCTIONS ON FILLING EMERGENCY CARE FORM.**

1. Fill the patient’s particulars as they appear in the patient’s file.
2. Particulars should be in capital letters.
3. Put a tick ‘v’ to indicate to the appropriate box.
4. For sex, circle M for male and F for female.
5. Record the time at which the patient arrived.
6. Triage category; tick ‘v’ into ‘emergency, priority or queue box if the patient condition follows in such category.

* Emergency patients are those with life-threatening problems.
* Priority patients are those who require medical attention within a few hours, such a disorder is acute but not necessarily severe.
* Queue are patients whose condition does not require immediate resources from an emergency medical system such disorder is minor or not acute.

1. Write a description of chief complaints. This information is obtained from the patient or relatives.
2. Check and record vital signs, if there are any abnormal vital signs; perform an appropriate intervention immediately.
3. Assess the airway, breathing, circulation, pulse and skin and then circle the appropriate term.
4. Assess the appropriate Glasgow Coma Scale (GCS) and record.
5. If the patient has any allergy; please specify.
6. Take medical history and tick “v” to the respective disease.
7. Take surgical history and tick ‘v’ in option boxes provided.
8. Take reproductive health (female) history tick ‘v’ in option boxes provided.
9. Assess Ear, Nose, T, respiratory, cardiovascular, Central Nervous System, Gastro Intestinal (GI)/ Genital Urinary (GU) systems, activities and skin status and respond accordingly.
10. All information about the investigation done must be filled correctly.
11. Results will be extracted from the investigation form.
12. Monitor intake and output accordingly.
13. Monitor patient parameters continuously until disposed of from an emergency.
14. The time of decision and action during the disposition of patients at the emergency unit should be filled accordingly.
15. List the patient’s properties and keep in an appropriate place.
16. Use initials to represent names of the health care provider who attended the patient like Dr (Doctor), Nursing Officer (NO), Assistant Nursing Officer (ANO), Nurse (N), Medical Attendant (M/ATT).

**FORM NO 11**

|  |  |  |  |
| --- | --- | --- | --- |
| UNITED REPUBLIC OF TANZANIA  MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN  C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps23.png  NAME OF HEALTH FACILITY  ………………………………………………………………................. | | | **EMERGENCY CARE FORM**  Hospital Reg. Number……...….…………………..................................  Surname………………………………..…First Name.…………..………………  Middle Name …………………….….……………..Age………Sex……..M / F  Religion………………….…..…………….…..Tribe…………………......……….  Ward/Unit…………………..Next of kin……………………………………………  contacts of next of kin………………………………………………………….. |
| Arrival Time ……………… Date …………….……………Received by ………………………………………………….Designation ………….………… | | | |
| **A: Triage Category:** Emergency **C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps25.png** Priority **C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps26.png** Queue **C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps27.png** | | | |
| Chief Complaint: ………………………………………………………………………………………………………………………………………………………………………………………………………………….…………………………………………………………………………………………………………………………………………………….  When did the illness begin? ……………………….....………………………………………………………………………………………………………………………………………………..………………………………………………………………………………………………………………………………………………………………………………………. | | | |
| Initial Vital Signs: PR …………….………… RR …………………….….. BP……………….….…….. TEMP…………………..…… SPO2……………………………………RBG ………………..…….. | | | |
| **C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps28.pngC:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps29.png**Airway: Clear Obstructed: (Partially / Complete ) | | | |
| Breathing: Normal **C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps30.png** Mild Labored **C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps30.png** Severely Labored **C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps30.png** | | | |
| Circulation: Cap Refill<3seconds **C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps33.png** Cap Refill>3seconds **C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps33.png** | | | |
| Pulse: Normal **C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps34.png** Rapid **C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps34.png** Weak **C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps34.png** Nil **C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps34.png** | | | |
| Skin Intact: Yes No (If ‘NO’ proceed to assessment) | | | |
| Neuro GCS (Glasgow Coma Scale): Eye ……… Verbal……………… Motor………………………Total…………………………………. | | | |
| Allergies: Medication …………………………………..… Food ……….…….……………………. Any other …………..……………………………….. None …………………………………… | | | |
| Current medications: 1……………………………….……………………………………………… 2…………………..….……………..……………………… 3…………………………….…………………………………………………………………….. 4…………..……………………………………………………………. | | | |
| **B: Medical History**: Diabetes C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps35.png Hypertension C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps35.png TB C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps35.png HIV/AIDS C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps35.png Seizures C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps35.png Sickle Cell Disease C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps35.png Asthma C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps35.png COPD C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps35.png Heart Disease C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps35.png Cancer C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps35.png Hepatitis A/B/C C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps35.png Stroke C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps35.png Other …………………….…………………… | | | |
| **Surgical History (type & date):** Obgy C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps51.png Ortho C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps51.png General Surg. C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps51.pngNone C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps51.png Other C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps51.png | | | |
| **Reproductive History (females):** LNMP……………….…….. Pregnancy: Yes C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps52.png No C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps52.png Unknown C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps52.png | | | |
| **C: ASSESSMENT** | (Put N for Normal and A for Abnormal) | DESCRIBE ABNORMALITY | |
| Head/Ears/Eyes/Nose/Throat |  |  | |
| Pupils equal and Reactive |  |  | |
| Sclera color |  |  | |
| Speech Facial |  |  | |
| Facial symmetry |  |  | |
| The moisture of mucous membrane |  |  | |
| **Respiratory** |  |  | |
| Breathing |  |  | |

**Nursing Services Forms Version 1**

|  |  |  |
| --- | --- | --- |
| Breath sounds |  |  |
| Bilateral Chest Expansion |  |  |
| **Cardiovascular (CV)** |  |  |
| Rhythm/Rate |  |  |
| Capillary Refill <3seconds or >3sec |  |  |
| Oedema (Present/Absent) |  |  |
| Pulse (use codes bellow) |  |  |
| *0 = Absent*  *+1 = Weak*  *+2 = Normal*  *+3 = Strong*  *+4 = Bounding*  *NB: Sites: (Radial R/L, Brachial R/L, Femoral R/L, Dorsal Pedis R/L).* |  |  |
| **GI/GU** |  |  |
| State of Abdomen (soft/hard/distended/tender) |  |  |
| Bowel movement |  |  |
| Stool: (Consistency/Color/Pattern) |  |  |
| Weight (General appearance) |  |  |
| Appetite/last meal |  |  |
| Vomiting: (Amount/Color) |  |  |
| Urine (Color/Sediments) |  |  |
| Urination (pain, frequency and amount) |  |  |

**Nursing Services Forms Version 1**

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| --- | --- | --- |
| Mobility |  |  |
| Movement of extremities |  |  |
| **Skin** |  |  |
| Skin Color: Pale/Cyanotic/Jaundice/Necrotic |  |  |
| Skin Turgor: Loose/Tight |  |  |
| Skin Condition: Dry/ Moist/Intact |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **D: Procedures and Investigations** | | | | | | | |
| **Items** | **Result** | **Time** | **Done by** | **Items** | **Result** | **Time** | **Done by** |
| MRDT |  |  |  | RBG |  |  |  |
| UPT |  |  |  | RBG Repeat |  |  |  |
| HIV Rapid Test |  |  |  | CBP/FBP |  |  |  |
| Catheterization |  |  |  | CCP |  |  |  |
| FAST US |  |  |  | Blood Grouping & Cross match |  |  |  |
| X-Ray |  |  |  | B/S |  |  |  |
| CT Scan |  |  |  | ABG |  |  |  |
| Intubation |  |  |  | I-Stat |  |  |  |
| ECG |  |  |  | CG4 |  |  |  |
| Other…………… |  |  |  | Other ……………………… |  |  |  |

**Nursing Services Forms Version 1**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Output** | | | | | | | |
| Time | Fluid (urine/gastric/chest tube/blood) | | Amount (mls) | | Comment (color, odor) | | Recorded by (name) |
|  |  | |  | |  | |  |
|  |  | |  | |  | |  |
|  |  | |  | |  | |  |
|  |  | |  | |  | |  |
| **Reference: Glasgow Coma Scale** | | | | | | | |
|  | | Adult | | Child | | Infant | |
| Eye Opening | | 4. Spontaneous | | 4. Spontaneous | | 4. Spontaneous | |
| 3.To Speech | | 3. To Speech | | 3. To Speech | |
| 2. To pain | | 2. To Pain | | 2. To Pain | |
| 1. Nil | | 1. Nil | | 1. Nil | |
| Best Verbal Response | | 5. Oriented | | 5. Oriented | | 5. Coos and Babbles | |
| 4. Confused | | 4. Confused | | 4. Irritable cries | |
| 3. Inappropriate words | | 3. Inappropriate words | | 3. Cries in response to pain | |
| 2. Incomprehensible sound | | 2. Incomprehensible sound | | 2. Moans in response to pain | |
| 1. Nil/Tube | | 1. Nil/Tube | | 1. Nil | |
| Best Motor Response | | 6. Obeys commands | | 6. Obeys commands | | 6. Moves spontaneously | |
| 5. Localizes | | 5. Localizes painful stimulus | | 5. Withdraws to touch | |
| 4. Withdrawal | | 4. Withdrawal to pain | | 4. Withdraws to pain | |
| 3. Abnormal Flexion | | 3. Flexion to pain | | 3. Flexion to pain | |
| 2. Extension (abnormal) | | 2. Extension to pain | | 2. Extension to pain | |
| 1. Nil | | 1. Nil | | 1. Nil | |

**Nursing Services Forms Version 1**

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| **E: Observation Sheet** | | | | | | | | | | | | | | |
| Vital Signs | | | | | | | |  | Intake/Medication/Blood | | | | | |
| Time/Date | | BP | PR | | RR | SPO2 | | TEMP | Date/Time | Medication/Fluid | | Dose | Route | Done by |
|  | |  |  | |  |  | |  |  |  | |  |  |  |
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| **F: Disposition** | | | | | | | | | | | | | | |
| The patient condition upon leaving EMD …………………………………………………………………………………………………………………………………………………………………………….. | | | | | | | | | | | | | | |
|  | Decision time | | | Action time | | |  | | | | Properties | | | |
| Theatre |  | | |  | | | Checklist completed Report YES **C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps52.png** NO **C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps52.png**  Escorted by ……………………………………………….  Received by ……………………………………………… | | | |  | | | |
| Admit |  | | |  | | | Ward……..……..…. Escorted by ………….………… received by ………………….  With: Ambulance Stretcher Wheelchair | | | |
| Discharge |  | | |  | | |  | | | |
| Death | Time Certified | | | To Mortuary | | | Time Pronounced……………………………..  By …………………………………………………….  Death Certified & Signed | | | |

**Nursing Services Forms Version 1**

FORM NO 12: PATIENT REFERRAL FORM.

This form is used to refer patients from one facility to another to ensure continuity of care, safety and improvement of health services.

**INSTRUCTIONS ON FILLING PATIENT REFERRAL FORM**

1. Fill patient’s particulars (ask patient/relatives, check the patient’s file).
2. Particulars should be in capital letters.
3. Circle M for a male patient and F for a female patient.
4. The date of referral is the day on which the patient is transferred to another facility.
5. Reasons for referral; specify exactly the service the patient is expected to get.
6. Vital signs should be checked before the patient leaving the facility.
7. Full names and signature of referring, escorting and receiving personnel must be written clearly.

* Referring to personnel is the one who the decided on referral.
* Escorting personnel is the one accompanying the patients.
* Receiving personnel is the one who received the patient at the referred facility.

1. The designation will be initials like CO (Clinical Officer), AMO (Assistant Medical Officer), MO (Medical Officer), Specialist, NO (Nursing Officer), ANO (Assistant Nursing Officer), N (Nurse), M/ATT (Medical Attendant)
2. The referral form should bear the official stamp of the referring facility.
3. Feedback leaflet will be filled by receiving hospital/facility/unit and sent back within one week to the referring unity/facility.

**FORM NO 12**

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| --- | --- |
| UNITED REPUBLIC OF TANZANIA  MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN  C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps55.png  NAME OF HEALTH FACILITY  ………………………………………………………………........... | **PATIENT REFERRAL FORM**  Hospital Reg. Number……..….………………………………........................  Surname………………………………………First Name.…………..……………... Middle Name ………………….…………….Age………Sex…………..M / F  Religion……………….……………………….Tribe……………..…….......……….  Ward/Unit….……………………………………………………………. |

Date of Admission…………................… Referral Serial No…………… Medical Diagnosis…………........…………………………………..……

|  |
| --- |
| Referral to ………………………………………………………………………………Date of Referral …………..……………….. Time ……………… |
| Present chief Complaints |
| Patient’s History |
| Physical Examination |
| Provisional/Final Diagnosis |
| Investigations |
| Treatment given prior referral |
| Reason(s) for referral |

**Nursing Services Forms Version 1**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Vital signs prior referral | | | | | | | |
| BP | PR | RR | SPO2 | TEMP | RBG | GCS /AVPU(Alert, Verbal response, Pain response, Unresponsive) | TIME |
| Referring Personnel …………………………………………..Designation ……….. Signature/Stump ………..………….…. Time…….……..  Escorting personnel ……………………………………………………..Designation …………… Signature……….…………Time……….……  Receiving personnel……………………………………………………… Designation …………….Signature…………………Time……………..  *NOTE: One copy of referral form should be returned to the referring health facility* | | | | | | | |

|  |
| --- |
| **Feedback leaflet**  Name of the Hospital…………………………………………………………………Department………………………………………………………………  Patient Full Name…………………………………………………………………… Referral serial No………………………………………………………  Referral Diagnosis………………………………………………………….………..Confirmed Diagnosis………………………………………………....  Comments …………………………………………………………………………………………………………………….………………………………………..  …………………………………………………………………………………………………………………………………………………………………...…………  Name of the Dr./Staff……………………………………………………………..Designation…………………… Signature/Stump…………………… |

**Nursing Services Forms Version 1**

# FORM NO 13: LAST OFFICE FORM.

This form will be used to verify the care given to a deceased body. The form will be used by all care providers who cared the deceased body from the time of death to preservation.

**INSTRUCTIONS ON FILLING LAST OFFICE FORM**.

1. Fill in particulars of deceased body as they appear in the patient file.
2. Particulars should be in capital letters.
3. Put tick ‘v’ to the appropriate box.
4. Specify any unusual issue. e.g. missing body part or any surgical implants.
5. Full names of care providers conducted last office, who have taken the body to the mortuary, and who received dead body should be written.
6. Use initials to represent the designation of the health care provider attended the patient like CO (Clinical Officer), AMO (Assistant Medical Officer), MO (Medical Officer), SP (Specialist), NO (Nursing Officer), ANO (Assistant Nursing Officer), N (Nurse), M/ATT (Medical Attendant).

**FORM NO 13**

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| UNITED REPUBLIC OF TANZANIA  MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN  C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps57.png  NAME OF HEALTH FACILITY  ………………………………………………………………....... | **LAST OFFICE FORM**  Hospital Reg. Number……..….………………………………................................  Surname…………………………………………First Name.………..……..……….……. Middle Name ………………….…..…………Age………………Sex…………..M / F  Religion……………..….……………………….Tribe………..….......……………………..  Ward/Unit……………………………………………………………… |

Death Certified by ……………………………………………Designation ………Signature……………Date ………………………Time……....

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| S/N | BED No. | DOA | FINAL  DIAGNOSIS | DOD | TIME OF DEATH | CAUSES OF DEATH |
|  |  |  |  |  |  |
|  | ITEMS | | | YES | NO | NA |
| 1 | Deceased particulars correctly filled | | |  |  |  |
| 2 | Deceased eyes closed | | |  |  |  |
| 3 | Limbs straightened | | |  |  |  |
| 4 | Jaws closed and supported | | |  |  |  |
| 5 | All medical devices, ornaments and dentures removed | | |  |  |  |

**Nursing Services Forms Version 1**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 6 | Open wounds covered with water proof dressing | |  |  |  |
| 7 | Three labeled tags prepared | |  |  |  |
| 8 | All orifices packed with cotton wool | |  |  |  |
| 9 | First labeled tag is placed around the wrist joint | |  |  |  |
| 10 | Second labeled tag is placed around the ankle joint | |  |  |  |
| 11 | The dead body is wrapped | |  |  |  |
| 12 | Third tag is placed on the chest | |  |  |  |
| 13 | Personal belongings secured and labeled | |  |  |  |
| 14 | Burial permit is available and correctly filled | |  |  |  |
| 15 | Mortuary Attendant informed | |  |  |  |
| Any unusual issue to be reported  YES C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps59.png NO C:\Users\LENOVO\AppData\Local\Temp\ksohtml4988\wps59.png | | If YES explain ……………………………………………………………………………………………………………………………………………….…………………………………………………………………………………………………………………………………………………………  …………………………………………………………………………………………………………………….…………………………………… | | | |

Names of 1ST care provider conducted the Last office……………………Designation……..…..Date………………Time……......……..

Names of 2ND care provider conducted the Last office……………………Designation……..….. Date………………Time……...………

Sent to the mortuary by…………………………………………..…………………Designation……………Date………………Time .……………

Received by ………………………………………………………………………………Designation ………….Date ………………Time ……………

**Nursing Services Forms Version**