Cabinet structure, equipment and work team

The conditions that must be met by the space, the equipment and the work team are regulated by:

- **Public Health,**
- **College of Physicians,**
- **House of Health Insurance**

and are checked on the occasion of the accreditation of the medical office.

Space conditions

1. The cabinet must be indicated by a company containing the name, rank and specialty of the doctor

2. Easy access for persons with disabilities (ramp) must be ensured

- Consultation cabinet with a minimum area of 14 sqm, provided with washable floor (tiled or linoleum) and sink;
- Treatment room provided with a sink;
- Sterilization room with sink;
- Vaccination office;
- File;
- Room for laboratory investigations and functional explorations;
- Room for nurses;
- Material storage;
- Office;
- Toilet
- Isolator for communicable diseases

Waiting room equipped with:

- chairs, tables, information leaflets,
- work schedule (cabinet and field),
- the name and rank of the nurse,
- posters on patients' rights and obligations,
- smoking ban,
- prohibiting access to animals,
- scheduling consultations and exams,
- price list for services that are not settled by Health Insurance House)

Hygienic and sanitary conditions:

- To be healthy
- Have natural light
- To be connected to the electricity grid
- Have running water
- Have a heating source
- To comply with the conditions for the disposal of biological waste (contract with a company for the incineration of biological waste, accredited by Health Insurance House)
- Have a phone.

Equipment conditions

A. Consultation office

- desk, chairs, wardrobe, hanger
- sofa of consultations
- Consultation table for infants
- tool table
- gynecological table and foot lamp
- tensiometer, stethoscope
- thermometer
- scale for adults and infants
- such as a tonometer, a pediometer
- pelvimetru
- centimeter
- tongue depressant;
- mouth opener;
- reflex hammer
- X-ray negatoscope;

A.1. medicine cabinet

- marked with "dead head"

- to have authorization for toxic substances specifying the persons who have access

- booklet for the discharge of medicines

- list of existing drugs

- the medicines are on time.

A.2. small surgery kit

- see vendors,
- tool boxes,
- scalpel, scissors, needles, holder, thread, pens
- gynecological valves and neck braces;
- rectal cannula;
- urethral cannulas;
- vaginal cannula;
- auricular spec
- Guyon syringe for ear washes;
- atele Kramer;

A.3. materials:

  - wadding,
  - sterile compresses, facies,
  - adhesive
- disposable syringes
- antiseptic solutions:
  - hydrogen peroxide,
  - rivanol,
  - sanitary alcohol,
  - betadine
- antiseptic solutions for instrumentation:
  - chloramine
  - Secusept

A.4. optional:

- oscilometer,
- otoscope, ophthalmoscope,
- EKG, ultrasound,
- meter

B. Treatment room:

- treatment sofa
- tool table
- waste containers
- refrigerator for vaccine storage,
  - thermometer for refrigerator
  - notebook with daily temperature record.

C. Sterilization room:

- pupinel or autoclave
- sterilization record book, daily biochemical test strip, name of person who performed sterilization, monthly biological test performed by sanepid.
- on the boxes and boxes the date and time of sterilization must be passed.

The work team:

1. Holding physician FD in contractual relationship with CNAS

2. Generalist medical assistant obliged to work with a book (with 1/2 time for offices with less than 1,000 patients, full time for more than 1,000 patients, two assistants for more than 2,000 patients)

3. Optional:

- FD doctors employed or other specialties
- psychologists
- Nursing assistant
- hygiene assistant
- midwife
- social assistance
- Secretary
- Accountant and Administrator
- computer scientist
- auxiliary personnel

Working hours:

• doctors - 7 hours daily program, of which at least 5 hours of practice and the other field

• assistants - daily program of 8 hours of which at least 5 hours of practice. Nurses have a daily record of treatments.

• in periods of absence less than 2 months, the FD will organize the taking over of the activity by another accredited doctor, and for absences greater than 2 months the CNAS will appoint a substitute doctor.

The records and forms used in the FD office

A. Basic evidence

1. The capitation list:

• updated monthly when reporting to the insurance company
• includes the identity data of the patients
• the category of which the insured belong
• date of entry on the capita list of the current family doctor.

2. Consultation form:

• necessarily include the identity data of the patients
• proof of the quality of insured - for those who receive free prescriptions: the supporting document (war veteran card, political prisoner, revolutionary certificate, disabled, politically deported)
• the date and place of the consultation
• diagnosis and disease code
• recommended treatment
• recommendation of specialized consultations and investigations
• the results of the investigations
• the medical letters received from the outpatient or hospital specialists are attached.

3. Consultation register for patients 0-1 years and over 1 year,

In which all the consultations performed at the patient's office or at the patient's home are mentioned daily

- the order number
- the date and place of the consultation
- Name and surname of the patient
- Age, sex
- Address
- Medical record number
- Diagnostic
- Treatment
- recommendations

4. The treatment register, in which all the injectable treatments performed at the patient's office or at the patient's home, curative or prophylactic, are mandatory.
In it are inscribed:

- order number,
- time
- name and surname of the patient,
- age, sex,
- Address,
- treatment (drug name, pharmaceutical form, dose, mode of administration).

5. The immunization register, in which all the vaccinated children will be recorded by calendar years and months, according to the national program of round-ups.
The following will be mentioned:
date of birth,
name and surname of the child,
Address,
the dates on which the vaccinations were carried out.

6. The registration tables are used for the registration of patients who will benefit from certain medical services, respectively
name and surname of the patient,
CNP,
address, telephone directory
vaccinations performed,
balance sheet exams,
dispensing of chronic diseases,
screening exams.

7. Pregnant registry:

- the pregnant women recorded are recorded,
- pre- and postnatal consultations.
- order number,
- the date of the record
- pregnancy identification data,
- the age of the pregnancy at the time of recording.
- the dates of prenatal consultations by weeks of pregnancy, weight, waist, pelvisimetry, uterine height,
- the date of the last renovation,
- the date of the first fetal active movements,
- the probable date of birth,
- the characteristic pathology of pregnancy,
- evolution of weight and blood pressure,
- urine examination results,
- the blood group and Rh,
- the result of VDRL and HIV,
- vitaminizare
- Date of vaccination against tetanus
- Pregnancy history (number of pregnancies, births, abortions)
- The place where the birth is recommended
- Place and probable date of birth
- Data on the newborn
- Date of removal
- Date of granting pre- and postnatal medical leave
- Date of consultation of the Lehuza

8. The registry of patients with chronic diseases for adults and children. The register shall be renamed:

- order number,
- name and surname of the patient,
- date of birth,
- Address,
- the date of the record,
- diagnosis,
- the date of the periodic checks
- the date of removal.

In children it will be specified:

- **cases of common deficient rickets, anemia, malnutrition, prematurity, congenital malformations.**

9. The activity plan includes

the main objectives of the activity:

- the assistance of healthy and sick people
- primary prevention
- health education
- community assistance

specific objectives:

- Schedule of vaccinations
- BTS and TB screening
- Review of balance sheet
- Surveillance of pregnancy and leprosy

10. Register of home consultations (curative, prophylactic, active or passive):

- date, time,
- patient name,
- age,
- Address,
- diagnosis,
- treatment.

11. The register of the doctor's calls at the patients' home:

- time
- call time,
- the name of the applicant,
- health issue, date
- the date and time of the doctor's appointment.

B. Records

1. Register of infectious diseases of group A and B:

- name and surname of the patient,
- date of birth,
- residence,
- diagnostic,
- the date of the record,
- the date of removal.

2. Record book a

- angina STR,
- Acute diarrheal diseases
- tetanus wounds

3. The register of cases records of:

- diphtheria,
- malaria,
- rabies
- acute hepatitis,
- TB
- HIV AIDS,

- syphilis and other STDs,
- parasites etc.

4. Register of cases registration

- pneumonia,
- bronchopneumonia,
- flu (in the cold season) and cases
- acute diarrheal diseases (in the hot season).

5. Registry of epidemiological information: circulars received regarding the diagnosis and surveillance of contagious diseases that have appeared in the community.

6. Record with the reading of BCG scars

- calendar month,
- name and surname of the child,
- date of birth,
- the age of the child when reading the scar,
- the diameter of the vaccine scar;

7. Register with sterilizing record of the instrumentation provided:

- the date and time of sterilization,
- sterilization temperature,
- the sterilized instrument**;**

8. Register with vaccine scheduling:

- each one is recorded
- calendar month children born and highlighted as well
- the month when they will be scheduled for vaccinations.

9. Register of patients traveling to endemic areas:

- name and surname,
- date of departure from the country,
- date of entry into the country,
- place of travel,
- vaccinations performed,
- biological testing.

10. Record of the consumption of medicines from the emergency kit:

- time
- the patient's name,
- the type of drug used,
- the dose administered,
- existing stock;

11. Registry of records of drugs with special diet (narcotics);

12. Register of paraclinical investigations performed in the cabinet;

13. Register with the sources of drinking water (for rural areas only).

C. Forms used in the family medicine office

1. CNAS prescriptions used to prescribe drugs
released in compensated and free regime, are completed and generated
in electronic format;

2. Card with dry stamp prescriptions used for prescribing psychotropic (soothing) and narcotic drugs;

3. Book with simple recipes;
4. Card with reference tickets for paraclinical investigations - they are forms printed in 2 copies; one copy is delivered to the patient and one remains with the healthcare provider.
Includes data on:

- the insurance house to which the patient is insured
- medical unit,
- patient data (first and last name, CNP, address), clinical diagnosis,
- types of investigations recommended,
- the number of investigations requested,
- the date of issue of the sending ticket;

5. Notebook with reference tickets for specialized / inpatient consultation
are forms printed in 2 copies; one copy is delivered to the patient and one will remain with the healthcare provider. includes:

- the insurance house to which the patient is insured,
- medical unit,
- patient data (first and last name, CNP, address),
- clinical diagnosis,
- reason for sending;

6. Register with medical leave certificates: it is issued to the employed persons who cannot be present at the work place from
cause of temporary inability to work:

- acute illness,
- exacerbation / decompensation of chronic diseases,
- pregnancy and concussion,
- caring for the sick child,
- Medico-surgical emergencies,
- trauma and accidents,
- contagious diseases etc.

The maximum number of days of medical leave granted by the family doctor: 10 days, maximum 30 days in 3 stages in 365 calendar days from the date of the first day of medical leave.
7. Medical certificates for:

- exemption from absences due to illness,
- apt / inapt physical education,
- unemployment file,
- inclusion in categories of persons with disabilities, enrollment in school / college / faculty,
- departure abroad,
- exams,
- employment etc .;

8. Prenuptial medical certificate:

- patient data,
- the result of the clinical examination,
- neuropsychological evaluation,
- the result of VDRL and xRay;

9. Death certificate - issued after 24 hours after the death, by the family doctor, in the situation of the death patients enrolled on their own list of capitation and after finding the death.

Death certificate it is not issued by the family doctor in the following situations:

- sudden death,
- violent death,
- suspicious death,
- suicide
- homicide,
- death in public places,
- death from road accidents,
- drowning.

The certificate includes:

- the identification data of the deceased,
- date and time of death,
- date of registration,
- place of death,
- the name and specialty of the doctor who records the death,
- the causes of death, etc .;

10. The birth certificate can be completed by the family doctor only if the birth occurred at home and he assisted the birth. This may be the case in isolated rural areas. In other situations the certificate is issued from the motherhood where the child was born.

11. Epidemiological opinions :

- are valid for 24 hours and are required at the entrance of the child into the community.
- For Class 1 students only evidence of vaccination is required.
- Evidence of vaccination may also be required when traveling abroad, enrolling in various forms of education or competitions, as well as employment.

Statistical reports used in family medicine

The medical documents used in FD practice have the following roles:

- keeping medical information about patients;
- keeping the confidentiality of the medical information (in the case of the consultation files);
- making periodic statistical reports (monthly, quarterly and annual);
- carrying out epidemiological studies and scientific research.
- Reporting of current activity (centralizing medical activity for medical services): monthly / quarterly;
- total consultations,
- consultations by age groups,
- office / home consultations,
- number of treatments performed,
- number of pregnant women who are on record and who are on record,
- number of vaccinations;

2. Monthly reporting of vaccinations performed;
3. Analysis of the medical leave certificates issued:
• total number of medical leave issued;
• total number of days of medical leave;
• labor indicators:
- frequency index (IF} = number of medical certificates / total number of patients x 100;
- gravity index {IG) = no. days of medical leave / total number of patients x 100;
- average duration index {IDM) = IG / IF.
4. Monthly centralization of morbidity, new cases of illness, morbidity studied by incidence, which is by age group and the codifications are made according to the WHO list;
5. Centralizing new cases of infectious and parasitic diseases (some diseases are reported within 24, 48 or 72 hours after detection);
6. Centralizing morbidity studied by prevalence (new and old cases of illness);
7. Weekly reporting of acute diarrheal diseases in the hot season;
8. Weekly reporting of acute respiratory diseases in the cold season;
9. Monthly report on:
• numerical reporting of cases of: BDA, bacillary dysentery,
primary encephalitis, infectious encephalitis, influenza, epidemic parotiditis,
measles, trichinellosis, whooping cough;
• Nominal reporting of cases of: amoebic dysentery, anthrax, botulism, brucellosis, diphtheria, buton fever, Q fever, typhoid or paratyphoid fever, acute viral hepatitis, cholera, leischmaniasis, leptospirosis, malaria, epidemic meningitis, ornithosis, psoriasis. scarlet fever, tetanus, exanthematic typhus, tularemia, polio, pest.
10. Monthly reporting of communicable disease cases (BTS, TB) after confirmation by the specialist doctor;
11. Quarterly situation of their referrals to secondary / tertiary assistance:

- no. outbound tickets,
- no. sending paraclinical investigations,
- no. domestic tickets,
- no. medical letters received from the outpatient specialty / hospital;

12. Immediate reporting, by telephone, of special events (mass sickness, collective accidents, natural disasters etc.)