Konsulta Data Requirements

I. Health Screening & Assessment

a. Patient Primary Details
b. Authorization Transaction Code (ATC)*
    i. Allow tagging of walk-in if without ATC
c. Past Medical History*
d. Past Surgical History
e. Family History*
f. Personal/Social History*
g. Immunizations
h. Menstrual History
i. Pregnancy History
j. Physical Examination Findings (BP Measurements, Heart and Respiratory Rate, Body Measurements and Vision)*
k. Physical Examination Findings (Skin, HEENT, Chest, Heart, Abdomen, Neuro, Rectal and Genitourinary)
l. Blood type
m. General Survey
n. NCD Questionnaire
o. Laboratory Imaging Results (if 'Diabetes Mellitus' is selected in Family History)*
    i. RBS/FBS

All fields with asterisks (*) are the first patient encounter data.

II. Consultation

a. Subjective/History Of Illness
    i. Chief Complaint
    ii. History of Illness
b. Objective/Physical Examination
    i. Physical Examination Findings (BP Measurements, Heart and Respiratory Rate, Body Measurements and Vision)
    ii. Physical Examination Findings (Skin, HEENT, Chest, Heart, Abdomen, Neuro, Rectal and Genitourinary)
c. Assessment/Diagnosis
d. Plan/Management
e. Medicine
f. Laboratory Imaging Results