





TaifaCare OPD Clinical Encounter Workflow User Guide

[Last updated: Aug 2025]

Tasks:	End to end navigation of the OPD Clinical Encounter in Taifa Care
Objective:	Navigation skills
Who:	EMR users
Required Materials:	Username, password, computer installed with the latest version of Taifa Care

Step	Action	Screen Shots
Learning Objective	By the end of this session, you will be able to	
	 Successfully log into Taifa Care Successfully document a OPD clinical encounter in Taifa Care 	







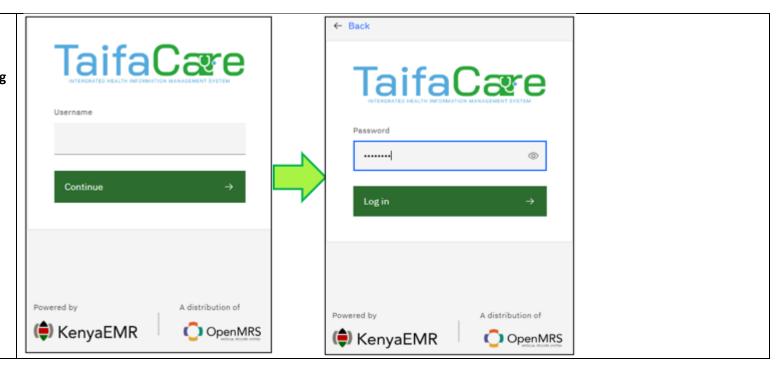
Step 1 Login to Taifa Care

Enter the application server URL System

"localhost:8080/openmrs/spa/log in" and click on the load b button or Enter key from the keyboard.

On successful loading, you should be navigated to the system login page.

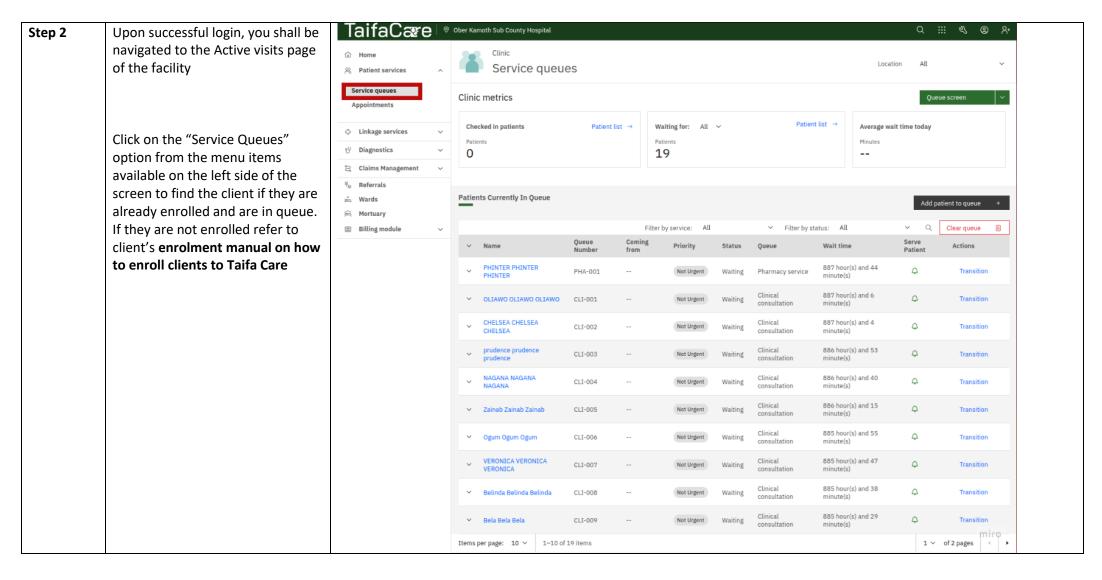
Authenticate entry by providing username and password on the fields, then. click "Login" button







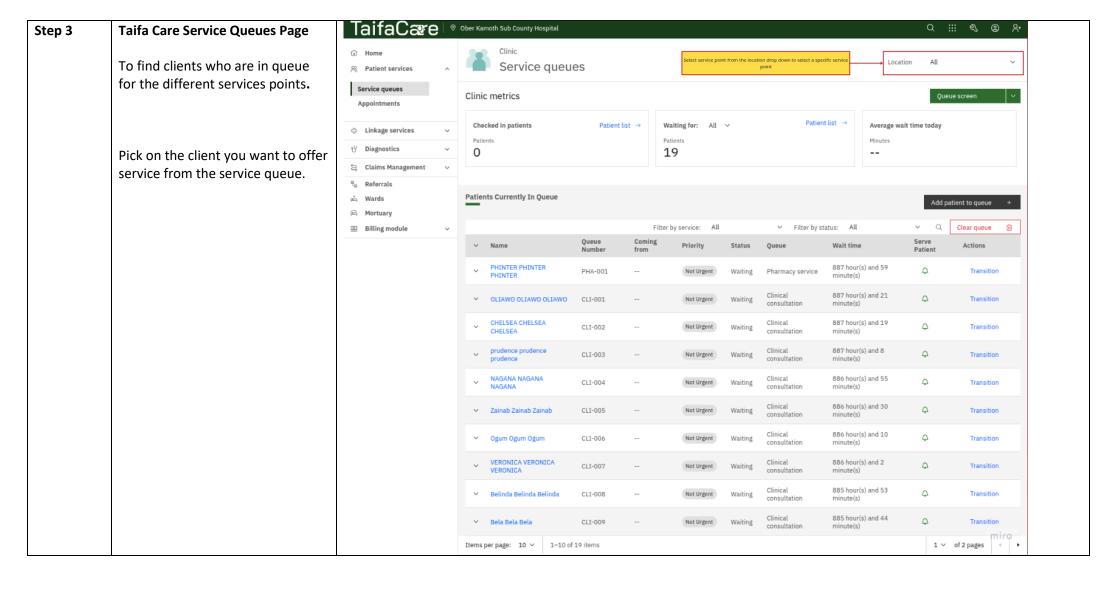


















Step 4 Clinical Encounter Form availability

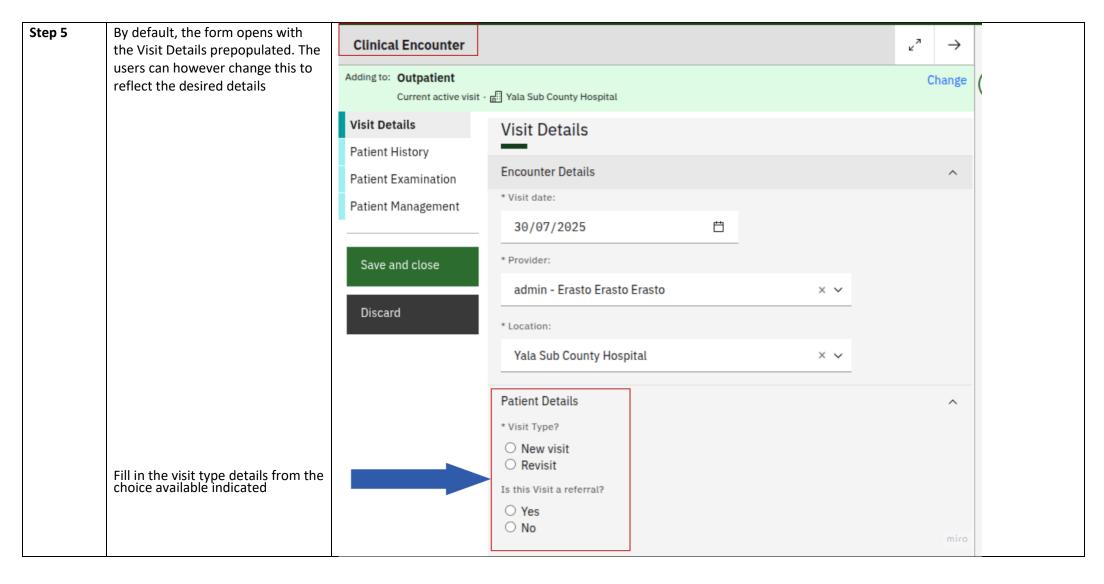
From the clinical suite of forms, the OPD clinical encounter form is one among the many available forms as captioned on the next column

Clinical forms	×	Ħ
Adding to: Outpatient Current active visit · 📶 Yala Sub County Hospital	Clinical forms	
Q Search this list		0
Form Name (A-Z)	Last completed	
Cancer Screening and early diagnosis	Never	
Clinical Encounter	Never	
Cross Border Referral	Never	
Cross Border Screening	Never	
Depression Screening PHQ-9	Never	
Generalized Anxiety Disorder Assessment	Never	
HIV Self Test Form	Never	
HTS Eligibility Screening Form	Never	
HTS Initial Form	Never	
HTS Retest Form	Never	
Nutrition Form	Never	
Progress Note	Never	
TB Screening	Never	
Triage	Never	
Violence Screening	Never	miro
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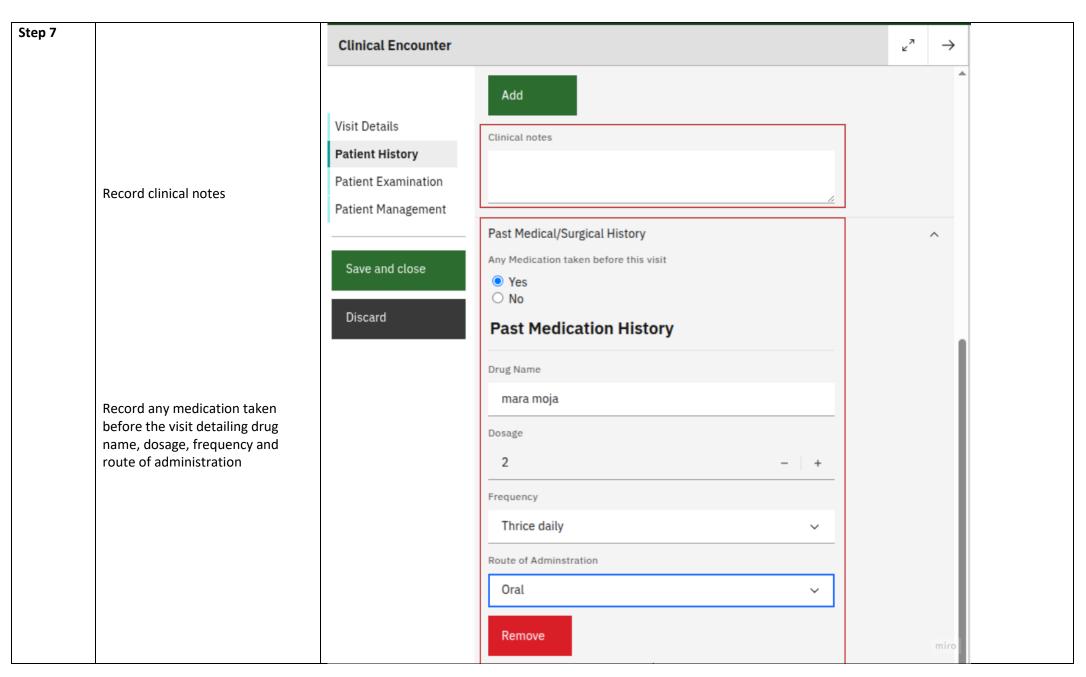


Step 6 Document **Patient History** usually **Clinical Encounter** \rightarrow presents and history of complaints from the select list and add to the Patient History grid. Numerous complaints can be added to the grid as reported by the patient. Complaints and History of complaints Visit Details * Patient having complaint(s) today? Include the duration of the **Patient History** complaint in days, Onset date and Yes Patient Examination onset status. O No Patient Management **Presenting complaints** min: 1 Save and close * Complaint Chest Pain Discard * Duration (Days) 7 **Onset Status** Sudden Remove















Step 8		TaifaCæ	9 Yala Sub County Hospital	
		Clinical Encounter		
	Screen patient for use of Herbal remedies and document	Visit Details Patient History Patient Examination Patient Management Any History of Trauma/Accidents Yes No Any History of Blood Transfusion Yes No Any History of Blood Transfusion Yes No Any Primary Doctor?		
	Record any medication taken before the visit detailing drug name, dosage, frequency and route of administration	Discard	○ Yes ○ No Any Surgical History ○ Yes ○ No Type of Surgery performed hysterectomy Date Surgery Performed? 13/08/2025 Indication of surgery: Tumour	miro







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Vala Sub County Hospital Step 9 **Clinical Encounter** Tumour Visit Details Any Admission History Record any admission history Patient History Yes indicating reason and date of O No Patient Examination admission Patient Management **Blood Transfusion** Date of Admission 13/08/2025 $\stackrel{\leftrightarrow}{\Box}$ Discard Adverse Drug Reactions * Patient has adverse drug reaction(s)? Yes Patient has adverse drug reaction(s) Medicine Causing Reaction Sulfonamides Reaction Itching Document any Adverse drug reactions the client might be Severity having. Indicate the causative Moderate medicine, reaction type, severity, Date of Onset date of onset and action taken. 13/08/2025 \Box Add as many adverse drugs as Action taken reported by the patient Family Planning Status Family Planning Status : Previous Visit Details Patient Examination







p 10 Patient Examination Document the General	TaifaCæe ® Yala Sub County Hospital		
Examination Findings as outlined	Clinical Encounter		
and make additional notes not captured in the multi select list	Adding to: Outpatient Current active visit · 🖫 Yala Sub County Hospital		
	Visit Details Patient History Patient Examination Patient Management Save and close Discard Patient Examination Findings: One		







Step 11	System Examination	Clinical Encounter			
Step 11	After conducting systems reviews on the client, document all the findings as per screening tool. Type down notes to elaborate further the systems' findings.	Visit Details Patient History Patient Examination Patient Management Save and close Discard	Restless Wasting General Examination Notes System Examination Finding(s) on systems review? All Systems Normal Abdomnal System Reviews Abdominal CNS CVS ENT Endocrine Eye Genitourinary Musculoskeletal Respiratory Skin		
			Abdomen findings Abdominal distension Abdominal mass Splenomegaly Hepatomegaly Abdominal tenderness Abdomen findings notes		
			Ascites present	9 6)







Step 12 Clinical Diagnosis

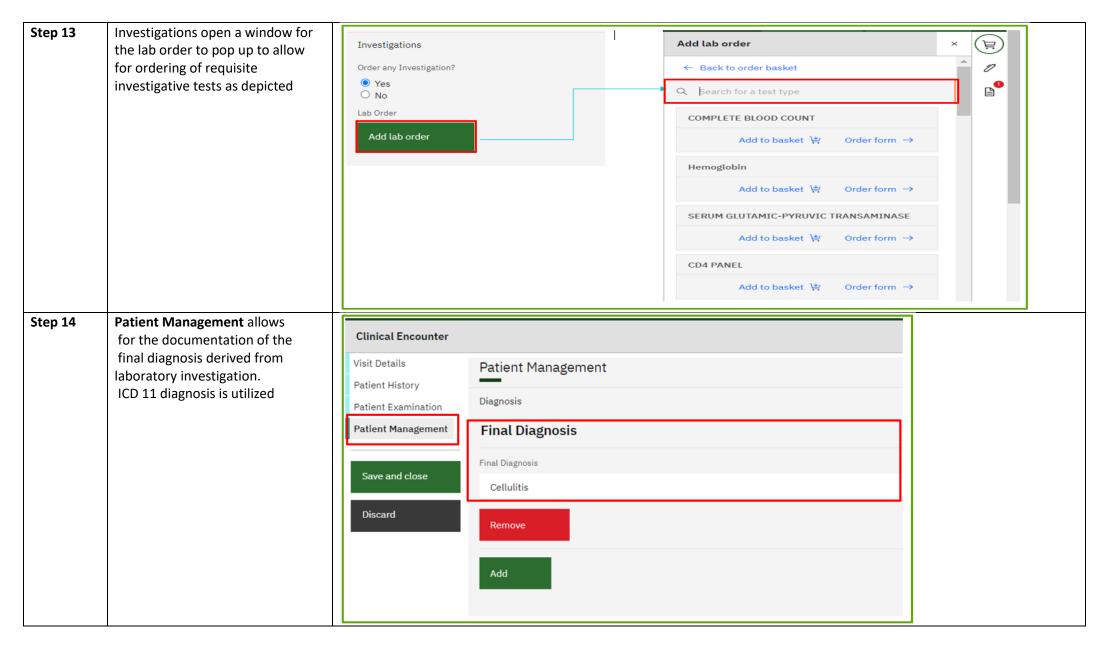
From the available ICD 11 diagnosis picker, Select the ailments that client has been diagnosed with during this visit empirically, based on the presenting conditions.

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AMOEBIASIS		J
Remove		
inical Diagnosis		
Abscess of Hand		
Remove		





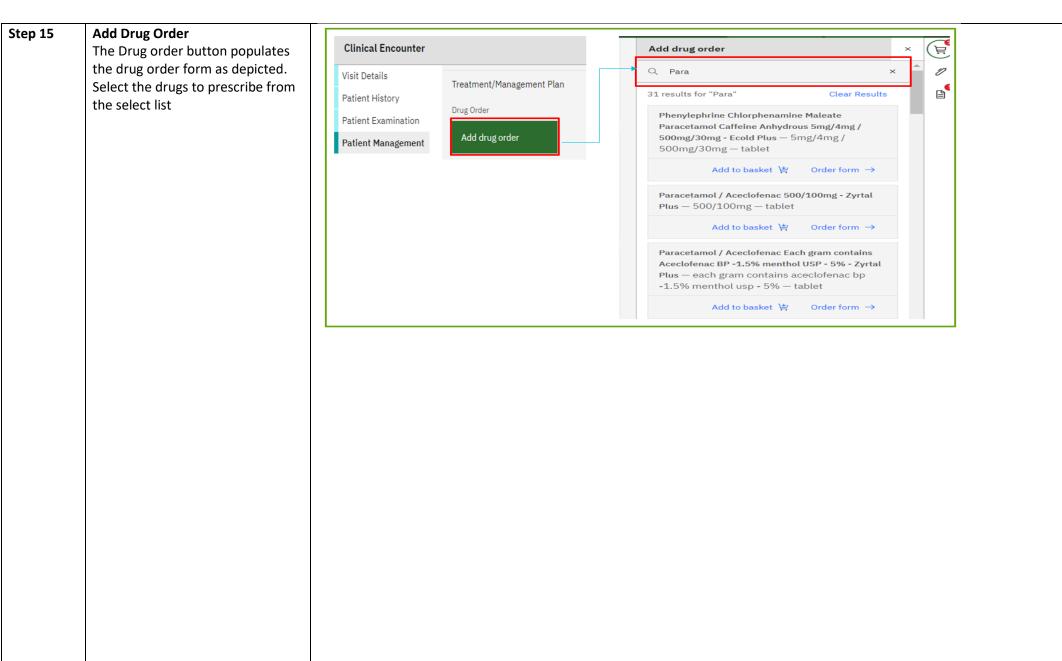










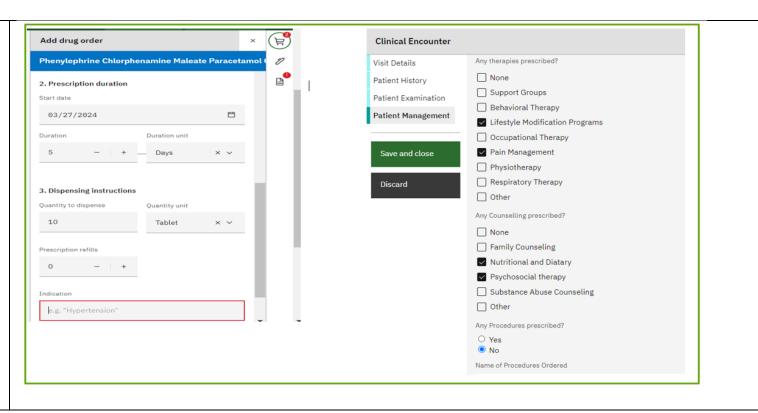








After ordering drugs get back to the clinical encounter to finalize the visit. Document any therapies, Counselling and procedures prescribed









Step 16	Click on Save and close to save and exit the clinical encounter	Any Procedures prescribed? Yes No Name of Procedures Ordered **Biopsy** Cannulation Patient Outcome Released Home Admit Referral Deceased	
		Appointments Add appointments	

THE END