PN-ABP-779
84062

Health Sector Financing Project
Ministry of Health
Republic of Indonesia

DEVELOPMENT OF THE UNIT SWADANA INFORMATION SYSTEM

Report No. 49

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September 3, 1992

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CHAPTER 1
EXECUTIVE SUMMARY

Under a subcontract with the International Science and Technology Institute (ISTI), the author has been assisting the Project Implementation Office/Hospitals (PIO/H) within the United States Agency for International Development (USAID) sponsored Health Sector Financing Project (HSFP) in Indonesia to design and implement a hospital-based computerized information system.

The present computerized hospital information system (HIS) has been designed with extensive collaboration among senior Department of Health Officials, management staffs of the five intervention hospitals, and several Indonesian subcontractors. The result is a system that is easy to use, flexible in responding to user demands for increased function, and able to respond to the information needs of health insurers under the proposed Health Law.

An objective of the hospital interventions is the development of a series of standard operating procedures that may be used by other hospitals. The information system, through its use of standardized codes, data entry protocols, and Department of Health reporting formats, is in line with the objective.

The dissemination of intervention results in a usable package requires the completion and assessment of the effects of the interventions, particularly the information system. The hospital interventions are scheduled for completion prior to March 31, 1993. Fundamental organizational change anticipated as hospitals become more independent take time to become manifest. A full assessment of the impact of the information system cannot be completed during the current ISTI contract. It is to the Ministry of Health's (MOH's) advantage to obtain and commit additional funding to continue the introduction and evaluation of hospital-based information systems.

A. BACKGROUND

Indonesia has made a commitment to decentralize its government hospital system. The term given to this concept is Unit Swadana. The process of decentralization authorizes government hospitals to retain tariffs for operational and maintenance purposes and not submit them to the exchequer as they are presently required to do. Other government regulations will also be relaxed, allowing hospital administrators to use more effective management practices to run their hospitals. Within the basic concept of Unit Swadana is the "acquisition and application of skills and knowledge needed to manage resources efficiently to provide medical services of high and uniform quality to the population" (Brotowasisto, Budihartono, H, et. al., 1990).

The Unit Swadana process will completely change the nature of financial and management needs within public hospitals. Unit Swadana will generate the need for information that does not currently exist within government hospitals. Financial information will be particularly important. It is the catalyst behind the development of the double entry accrual accounting system. For instance, unit costs are needed to measure the performance of each hospital department.

In addition to the computerization of the hospital's financial system, the present effort also computerizes the hospital's quality assurance and management information functions. Hospital statistics such as patient days, doctor office visits, average length of stay, and service intensity are calculated and used to estimate unit costs. Data contained within the medical record provide the basis of the computerized quality assurance system.

B. THE INFORMATION SYSTEM

The objective of the HIS is to improve the quality of medical decision making whether at a national or local level. It is used to assist management in policy formation, planning, budgeting, program implementation and evaluation. The system is designed to reduce problems of inaccuracy, incompleteness and unavailability of data, transcription errors and the delays that may occur in manual systems. The HIS allows the aggregation of data from many sources, the analysis of large volumes of data in a short time, and increased efficiency in the collection, validation, storage, retrieval, presentation and distribution of the data. The system supports the managerial routine operations of the health care organization, thereby contributing to overall efficiency and effectiveness.

There is a common organizational myth that only one computer system will provide a comprehensive management reporting system. The most effective management reporting systems are those whose designs are based on the capabilities of all systems existing in the facility and utilize the reports and other features of several systems. A manager might receive a set of reports from the financial management system, which provides the traditional revenue and expense department accountability. A case mix report might then present the analysis of patient services provided within the department and summarized per case profit and loss. Finally a productivity management system might provide series of reports to examine the aspects of productivity that are causing favorable or unfavorable department case-level profit or loss.

C. THE PRESENT SITUATION

On August 4, 1992, His Excellency, Dr. Adyhatma, Minister of Health, Republic of Indonesia, opened the first Unit Swadana hospital at R.S. Tegalyoso in Klaten, Central Java. A working prototype of the health information system was presented at that time. During August the computer software contractor, PT. Inti Inforama Sejahtera, has completed work on the system required prior to the installation and operator training at R.S. Fatmawati.

The present HIS contains two distinct modules. The financial module provides the double entry accrual accounting system required under Unit Swadana. It has been designed to incorporate standard Department of Health budgetary codes into a new hospital chart of accounts designed by Productivity and Quality Management Consultants (PQM). The financial module is capable of producing required Department of Health financial reports. The data contained within the financial model, when combined with the quality assurance (QA) and management information system (MIS), will be able to produce unit cost information along with other productivity measures.

The QA and MIS are contained in the second module. The central part of the QA system is the patient billing system. The billing system, using a set of standardized procedure codes, records all transactions associated with the patient's hospitalization or outpatient visit. The data combine with patient registration and diagnostic data to form a computerized medical record. The medical record database generates the patient's bill and may be analyzed to estimate the charges associated with different diagnostic categories. It is possible to electronically compare the patient's hospital treatment with the recently developed Indonesian Doctor Association's (IDI) Standards of Care to perform an initial assessment of the quality of patient care.

The MIS part of the module contains personnel information (e.g., salary, education, employment history) that conforms with Department of Health codes. Hospital facility data are recorded in this portion of the module. The data include numbers and classification of beds within the hospital as well as the number of outpatient clinics. The MIS produces a series of required Department of Health reports.

D. PATIENT CONFIDENTIALITY

The design of the present HIS has incorporated a series of measures to ensure patient confidentiality and hospital financial data security. Each data entry and viewing screen has a security level associated with it. Each operator of the HIS is given a password and an authorization level before being allowed to use the system. The passwords are contained within an encrypted portion of the system. Only operators with the appropriate authorization level may gain access to different parts of the system. For instance, the Hospital Director has access to the entire system, while a financial analyst is not able to view patient medical record data.

E. COMPUTER VIRUSES

The precautions employed to maintain medical record and hospital financial confidentiality also reduce the threat of computer viruses. In addition, the hospitals have been provided software which further reduces the risk. Education of computer users provides the best prevention and should be part of any future training efforts.

F. INFORMATION SYSTEM FLEXIBILITY AND FUTURE GROWTH

The present HIS has been designed to be responsive to user needs and able to grow as the hospital commits more resources to the system. The system's financial, billing, medical procedure, and pharmaceutical codes may all be updated by the user. The financial, facility and patient data are all contained in a series of Dbase files that comprise a relational database. As such, the hospital has the raw input for more sophisticated statistical and cost accounting analyses.

The flexibility also encourages the widespread adoption of the HIS. Each hospital faces different markets and operating constraints. The HIS allows for the entry of different procedures and prices specific to the hospital. As a result, the HIS may be introduced with limited modification to numerous hospitals throughout Indonesia.

G. SUSTAINABILITY

The present HIS will be sustainable in the long run if there is a demand from hospital management for the information it produces . The maintenance of the hardware and continued training of the operators requires resources. Hospital management must plan and budget for such activities. In the short run, during the first stages of the Unit Swadana process additional outside funds may have to be provided. The funds should come from the Routine Operating Budget at either the central or provincial level. The MOH might also obtain additional resources from cooperating agencies such as the Asian Development Bank (ADB). The integration of HSFP activities with World Bank and ADB activities would go a long way in assuring the short-term resources required to sustain and expand health information systems.

H. INFORMATION SYSTEM RELATIONSHIP TO JPKM

The HIS has been designed to interface with the reporting requirements of managed care plans under the new JPKM scheme. The patient's health insurance carrier and number are recorded at time of admission. The HIS can even handle several different tariff structures simultaneously. The linkage of the patient's health insurance number with patient charge data will allow the managed care plan to monitor the care its members receive, thereby increasing the demand for efficiently produced quality care. Of course, the extent that the health plan has access to patient data is limited under Indonesian law and any contractual arrangements between the plan and the hospital.

I. INFORMATION SYSTEM RELATIONSHIP TO PHARMACEUTICALS

The HIS has the ability to record the types and amounts of pharmaceuticals consumed during a hospital stay. The hospital determines the degree of specificity in the drug file. The drug utilization files may then be linked to the proposed drug procurement system currently being developed as part of the HSFP's pharmaceutical component. Patient drug utilization data may also be compared to the IDI standards of care as part of a QA program or used by a JPKM provider as part of their cost containment efforts.

J. THE FUTURE HEALTH INFORMATION SYSTEM REQUIREMENTS

The present health information system is designed as a prototype system that may be replicated in private and public hospitals throughout Indonesia. It provides a minimum data set and analytic procedures to assist the hospital transition to Swadana status. The system is designed to be flexible to user demands and is able to grow as the demand for reliable and timely information increases.

The introduction of computerized health information systems into government hospitals should proceed with due caution. There is the potential for significant increases in productivity and efficiency resulting from better uses of information. At the same time, it is also a possibility that the information system may add yet another data entry burden on the hospital. The careful design of the information system and the close collaboration between the contractors, the Department of Health, and the hospitals increase the likelihood of the former. The initial interventions are designed to be implemented in five hospitals. More resources need to be devoted to analyzing the success of the current effort prior to the widespread dissemination of the new technology.

K. HARDWARE AND SOFTWARE REQUIREMENTS

As the demand for information increases, additional hardware and software will be required. At present the 300 Megabyte hard disk capacity restricts the amount of data the system may track. For instance, R.S. Fatmawati's outpatient clinics serve several thousand patients each week. Each visit generates numerous records in many different files occupying additional hard disk space. The hard disk's capacity will be exceeded in several months. Increased user sophistication will lead to more involved statistical analyses requiring greater amounts of random access memory (RAM). The analyses may best be accomplished through the use of outside statistical programs such as SAS or SPSS.

The amount of hard disk space or RAM required of the information system is a function of the tasks asked of it. For the purposes of the interventions the present configurations are quite adequate. It is important to carefully assess the information system's ability to meet user demands in the five hospitals before estimates of future requirements are developed.

L. COPYRIGHTS

It is the understanding of the consultant that the MOH owns the information system's object code, while the software contractor retains the rights to the source code. The compiled FoxPro2 derived information system may be distributed by the MOH without infringing on the FoxPro copyright.

The information system has been designed to provide maximum flexibility in allowing hospitals to define financial and procedural codes appropriate to their requirements. However, if the MOH or the hospitals decides to modify the basic functions of the system they will need to purchase a version of FoxPro2 from an authorized distributor.

M. PERSONNEL REQUIREMENTS AND TRAINING

The real constraint in the ongoing evolution of the HIS is the skills of the users. The users range from the operators who input the data, to the analysts reviewing the output, to the managers creating hospital marketing and pricing policy. The hospital must decide what resources it is willing to commit to improving personnel skill levels and acquiring additional staff. The development of standard operating procedures (e.g., financial and quality assurance) as part of the HSFP's hospital interventions is the first step in defining the skills required to operate the system. The automation of the hospital's personnel files will provide information to the Hospital Director as he or she estimates the need for additional training or staff.

The degree of sophistication of the HIS determines the levels of training required to introduce and maintain the requisite skills. As the HIS is introduced into the intervention hospitals, training will be provided. However, hospital management must commit itself to the continued training of personnel if the level of skills is to be maintained and the HIS is to continue to function.

The initial training as part of the introduction to the HIS should probably be conducted on site by the group installing the HIS. The use of training manuals developed by the HSFP may be used in the installation process. Ongoing training should be conducted on site by the operators trained during the initial installation. This ensures the institutionalization of the knowledge base required to maintain the information system.

The experience gained through the hospital interventions should be evaluated prior to suggesting the numbers, types, and qualifications of the users and subsequent widespread introduction of the computerized information system.

N. THE NEED FOR STANDARD CODES

The flexibility of the HIS allows the user to update and change a series of financial, procedural, and diagnostic codes. One of the objectives of the initial interventions is to develop a set of standardized codes that are applicable across hospitals. Coordination between the hospitals, Department of Health, and the contractors is essential to ensure the optimal amount of system standardization. Resources must be devoted to assess the impact of the current interventions prior to full-scale dissemination.

O. CONCLUSION

The present information system is an evolving tool that will assist Indonesian hospitals in becoming more independent in their operations. The system's financial, quality assurance, and management information components meet existing Department of Health reporting requirements as well as provide the flexibility to adapt to a rapidly changing environment.

Prior to further dissemination, the information system, its operating protocols and personnel training requirements should be carefully assessed to develop a package, or a series of packages most likely to meet the needs of hospitals under the Swadana concept.

The full assessment of the impact of the information system and subsequent design changes arising from such an assessment may not be completed prior to the expiration of the existing ISTI contract. The MOH, after the investment of considerable resources, has almost reached its goal of producing a set of management and information tools to be used by hospitals during privatization. It is to the MOH's

advantage to obtain and commit the additional resources required to complete this important and worthwhile task.

CHAPTER 2
THE UNIT SWADANA INFORMATION SYSTEM

A. INTRODUCTION

Under a subcontract with the International Science and Technology Institute (ISTI), the author has been assisting the Project Implementation Office/Hospitals (PIO/H) within the United States Agency for International Development (USAID) sponsored Health Sector Financing Project (HSFP) in Indonesia.

The consultancy started on June 15, 1992, and was completed on September 3, 1992. There was a field trip to Klaten, Central Java from July 31 to August 4 to install the computer information system prior to the Minister of Health initiating Unit Swadana at R.S. Tegalyoso. R.S. Hasan Sadikin in Bandung, West Java was visited on July 17, 1992. Numerous site visits to the three Jakarta hospitals also were completed during the consultancy.

This report provides general background information on the processes of Unit Swadana, information systems, information system policy and implementation strategies, and the medical record. The components of the information system are described in a technical section of the report. The activities of the consultancy are then reported. The appendices contain examples of the data entry screens and the reports that the system generates.

B. SCOPE OF WORK

Assist the local consultants and third party contractor in the following areas:

1. Determine, analyze and rank software needs assessment.
2. Assist the contractor in conceptualizing and developing software for the following:
   - Management Information Systems (MIS's):
     - Collection, compilation, storage, analysis, distribution and networking in the various hospitals, existing and planned data
   - Quality of Care:
     - Quality Assurance (QA) Software
     - Utilization Review
     - Infection Control
     - Risk Management
     - Medical Record Software
     - Reporting System
   - Financial System:
     - Accounting
     - Budgeting
     - Pricing
   - Interaction Software with Pharmacy and Social Finance Components of the Project.
3. Evaluate/advise on the various hardware systems to be used in the implementation phase.
4. Design trail applications and future expansion of developed software.
5. Help in the design of the computer security for the system.
6. Help in the design of the safety system against computer virus.
7. Develop an implementation time schedule, and a monitoring and evaluation time schedule for the software application and full implementation.
8. Develop a software training outline to be used by the contractor for all software components.

9. Produce a temporary report before leaving the country.
10. Submit a full length report within three weeks of returning to the host country.
11. Interact with relevant MOH/Hospital Officials in developing databases.
12. Meet with pertinent MOH/USAID individuals to brief the latter on the developing activities.

C. GENERAL BACKGROUND

Indonesia has made a commitment to decentralize its government hospital system. The term given to this concept is Unit Swadana. The process of decentralization authorizes government hospitals to retain tariffs for operational and maintenance purposes and not submit them to the exchequer as they are presently required to do. Other government regulations will also be relaxed, allowing hospital administrators to use more effective management practices to run their hospitals.

The Unit Swadana process will completely change the nature of financial and management needs within public hospitals. Unit Swadana will generate the need for information that does not currently exist within government hospitals. Financial information will be particularly important. It is the catalyst behind the development of the double entry accrual accounting system. For instance, unit costs are needed to measure the performance of each hospital department.

Each supervisor will be held accountable for his or her performance. Cost will become an important measure of how well hospital resources are being utilized. The costs of producing services may then be tied into pricing strategies. The pricing strategies are linked to marketing efforts and social financing schemes currently being supported by the HSFP Social Finance component. These interactions all depend on the development of information systems.

In addition to the computerization of the hospital's financial system, the present effort also computerizes the hospital's quality assurance and management information functions. Hospital statistics such as patient days, doctor office visits, average length of stay, and service intensity are calculated and used to estimate unit costs. Data contained within the medical record provide the basis of the computerized QA system.

The patient's medical record provides the basis for much of the information system. The medical record will be discussed at greater length in another section of the report. During a previous consultancy by Zukin, (ISTI 22) he suggested that the quality of data contained within the medical record was less than optimal. The introduction of the computerized QA subsystem within the overall hospital information system (HIS) will improve the quality of the medical record by requiring the presence of certain data points. The presence of variables and the standardization of reporting codes (e.g., diagnosis, services provided) within the QA system will encourage the inclusion of the items in the medical record. This might be encouraged through the use of financial incentives.

Zukin also noted that few hospitals had mechanisms to set and monitor quality of care standards. Recently the Indonesian Doctors Association (IDI) introduced standards of care for a number of common diseases. The present QA system, because it records diagnoses and the procedures performed in the hospital, is able to provide the information that may then be compared to the IDI standards of care.

Two of the objectives of Unit Swadana are to increase the efficiency with which hospital resources are utilized and increase the quality of medical services. The HIS provides the means to encourage hospital managers and physicians to pursue these objectives.

Within the basic concept of Unit Swadana is the "acquisition and application of skills and knowledge needed to manage resources efficiently to provide medical services of high and uniform quality to the

population" (Brotowasisto, Budihartono, H, et. al., 1990). The HIS provides the means to realize this concept.

D. BACKGROUND ON INFORMATION SYSTEMS

Information systems are sets of related records and procedures that are managed and performed according to logically consistent rules that produce information as their output. The elements of an information system are hardware, system software, application software, databases, procedures and personnel. The collection of applications software is sometimes called the application portfolio. Those who benefit from information systems, the users, can be anyone in the organization who needs information in order to make a decision, take action, or monitor a situation. The value of an information system is in its ability to output useful information.

MIS's are a specialized information system designed to support executives in the overall management of the organization. They tend to be comprehensive in scope, addressing all aspects of the business, rather than focused on a particular activity.

MIS's exist to support management activities and functions (e.g., operational control, management control, strategic planning). They encompass information storage and retrieval, command and control, database management and decision support systems. A decision support system supports the various stages of the decision making process: intelligence (search and discovery), decision design (generating alternatives), and choice.

There is a common organizational myth that only one computer system will provide a comprehensive management reporting system. The most effective management reporting systems are those whose designs are based on the capabilities of all systems existing in the facility and utilize the reports and other features of several systems. A manager might receive a set of reports from the financial management system, which provides the traditional revenue and expense department accountability. A case mix report might then present the analysis of patient services provided within the department and summarized per case profit and loss. Finally, a productivity management system might provide series of reports to examine the aspects of productivity that are causing favorable or unfavorable department case-level profit or loss.

E. HEALTH INFORMATION POLICY AND IMPLEMENTATION STRATEGY

There is a need for a National Policy on Health Information Systems. The Ministry of Health (MOH) already has a Center for Data Processing to standardize the use of data within the Ministry. The development of such policies helps to ensure that development and use of systems will proceed in a coordinated manner.

The health information system policy may require legislation, operational regulations and guidelines. The policy should consider the following areas:

1. Sharing and exchange of information.
2. Relative priority of different projects.
3. Education and training of health professionals.
4. Impact on health services.
5. Centralization and decentralization of information systems.
6. Problems of data security and privacy.

7. Definition of rights and levels of access.
8. Methods for choosing appropriate supportive technology.

At the policy level the technological considerations are concentrated on the need for standards. Standards are useful in that they facilitate the exchange of data. Communication between computers requires standards for hardware, software and communication protocols. Standards are needed to ensure the reliability and security of data. They are useful in system design, documentation, program development, program testing and training.

The human resources required to implement the MOH policies should clearly be stated. Policies on recruitment, education and developments are contained within this framework.

The implementation strategy should address such issues as:

1. Improved communication among managers, systems personnel and end users.
2. Development of standards of compatibility
3. Avoidance of systems that cannot be integrated
4. Maintaining a technological balance of hardware and software among users.

The policy must outline the structure of the information system. Such a strategy would include policies on hardware, software, application development and communication protocols. The hardware strategy must specify what type of computers, peripherals and linkages are appropriate to the organization. The software strategy should specify the operating systems and programming languages to be used as well as software packages and tools. The applications include database management systems, spreadsheets and statistical and graphical software. Ensuring the integrity and confidentiality of data must be part of the procedures for application development.

The human resource requirements of information system implementation must be considered in terms of numbers, levels of experience and balance of skills required. There must be efforts made to increase health managers' awareness of the capabilities of the information system and the tradeoff associated with cost and completeness of the system. There needs to be increased education of the health professionals directly involved with the system. The recruitment of new staff or the training of existing staff is an important area to consider.

There are many types of standards that should be addressed in the introduction of the information system:

1. Data standards
2. Technical standards
3. Work standards
4. Equipment standards
5. Training standards
6. Professional standards

The increased demand for health services has increased the need for good management and effective planning at all levels of the health system. This includes four main areas:

1. Policy Formulation and Broad Programming

   This area involves the development of long-term strategies and objectives based on previously identified priorities and assumptions. Intervention strategies involving choices in technology and human resources development are all part of the development of

policy. The information required is at the population level and in most cases can be aggregated from data collected at lower levels of the system.

2. Detailed Programming and Budgeting

   This may occur at the facility level and is concerned with decisions on resource allocation ensuring maximum compliance with the decisions taken at the policy and broad programming level. There is a need for information that permits comparison of anticipated performance with requirements. The system must allow the comparison of different activities, their costs and schedules.

3. Monitoring and Control of Implementation

   At this level, individual technical actions, expenditures and expendable resource utilization are recorded and monitored. The accounting system records each transaction. Individual staff actions and individual elements of service delivery may be recorded. Recording of these transactions in standard formats will allow the data to be used at this level and aggregated for use at higher levels for control and planning purposes. The systems include accounting, medical records, drug inventory and distribution, registration of births and deaths, immunization records, equipment maintenance and personnel registers. More sophisticated systems can provide information comparing budgets with expenditures, achievements with targets, dates of milestone achievements with targeted dates, actual use of personnel by program function with planned used, and utilization of supplies and equipment in planned use with current inventories.

4. Evaluation and Reprogramming

   Evaluation measures the efficiency, effectiveness and health of the health system to guide intervention decisions. This information must include the impact of established programs.

No one information system can fulfill all of these requirements. However, the systems should be conceived as a whole in order to ensure that the system is capable of supplying information to levels above, below or alongside.

F. HOSPITAL INFORMATION SYSTEMS

The objective of the health system is to improve the quality of medical decision making whether at a national or local level. It is used to assist management in policy formation, planning, budgeting, program implementation and evaluation. The system must be designed in order to reduce problems of inaccuracy, incompleteness and unavailability of data, transcription errors and the delay that may occur in manual systems. The information system should allow aggregation of data from many sources, analysis of large volumes of data in a short time, and increased efficiency in the collection, validation, storage, retrieval, presentation and distribution of the data. The system supports the managerial routine operations of the health care organization, thereby contributing to overall efficiency and effectiveness.

Several different information systems support hospital function. Systems used to support day-to-day operational actions are frequently called transaction processing systems. A transaction in a routine procedure generates at least one data item. The output is directed primarily towards reporting what happened over a specified period of time. Operational level systems include accounting packages, inventory and materials management systems, personnel systems, facilities management, health statistics databases and departmental record keeping.

Management control and monitoring systems are concerned with the analysis and interpretation of raw operational data. They are often termed management information systems (MIS's). They may be distinguished from transaction systems by the fact that they report on what occurred and compare it to what was expected.

The financial system should include the following activities:

1. Cash flow analysis
2. Financial balance analysis
3. Cost analysis
4. Budget planning and control

Another area that the information system should address is that of audit. Periodic audits carried out detect irregularities and assess both the level of quality of services and the status of human and material resources.

Health information systems have been extensively introduced at the hospital level. Their objectives generally stated are as follows:

1. Satisfy the data processing requirements of individual departments with stand-alone systems.
2. Make hospital operation more efficient by communication of patient data among hospital departments, processing of individual patient data, scheduling of patients and resources.
3. Support hospital management by providing administrators with timely data in an appropriate form for their decision making.
4. Provide physicians and allied health personnel with accurate and up-to-date medical information.
5. Store information pertaining to medical students and interns.
6. Provide specialized disease registers.
7. Provide efficient communication with health related facilities outside of the hospital.
8. Provide data for clinical research.

The MIS contains three basic subsystems. The operational subsystem processes data that belong to basic operations. There are reporting subsystems that inform the various organizational levels. Finally, there are decision support subsystems for both recurrent and one-time situations. The MIS will discriminate between and create the three basic subsystems in an integrated way so that all the elements are considered in relation to each other and so that the decisional effects can be easily measured. The MIS is flexible and represents the synthesis of each manager's changing information needs and takes into account his or her decision making responsibilities.

G. THE MEDICAL RECORD

The basis of the QA portion of the information system is found in the patient's medical record. Prior to describing the contents of the different information system components it is useful to review some pertinent aspects of the medical record.

The patient's health record is an integral part of the care given to the patient during hospitalization or attendance at a hospital or other health facility. It includes the collection of important data about the patient, the problems the patient may have or perceive him/herself to have, and the care given by the staff during hospitalization or treatment. It should commence at the first encounter or treatment at a hospital,

clinic, or primary health center and is the most important tool in relation to the care given to an individual patient.

With the current advances in medicine and computerization, the need to adequately manage both the health information system and all health record services is becoming more important in developing the hospital system.

Health records today are used as a basis for health care planning, medical education and research as well as current health care, health promotion and disease prevention. The management of health record services as a supporting tool requires the planning, design and analysis of health information systems, and the development, implementation and control of manual and/or automated health record systems. In addition, the services are required to assist with monitoring health care and health information systems to maintain specific standards of efficiency and effectiveness; to safeguard confidential health information from unauthorized access; and to collect, process and analyze clinical data via a specialized coding system for the production of useful and meaningful statistics on morbidity and mortality within the community.

The process of health record management commences with admission of the patient to the hospital or a visit to an outpatient clinic. The administrative data include patient identification such as name, address, date of birth, and next of kin. Also collected at this time are details of the patient's financial status in relation to health insurance, and basic clinical data that include the reason for admission and the proposed operative procedures for surgical patients.

The type of data and how they are collected varies from hospital to hospital with the current requirements of the local health authorities. The important issue is that the information collected should be clearly recorded on the admission form which subsequently becomes the front sheet of the patient's health record.

To ensure that the patient and the medical record are accurately and permanently identified, a medical record number should be issued on the first attendance or admission to the hospital. This is a unique number that differentiates one patient from another and ensures that all clinical data relating to an individual are filed together in that particular patient's health record.

The control of the number system is an important tool in the management of the health record system. To obtain this control, an accurately maintained number register and a precise procedure for number assignment must be instituted.

The major work of the health record service commences at patient discharge. At this point all clinical data should have been completed and the medical officer has recorded a discharge note and a written summary of the hospital stay. The final diagnosis has been recorded and the record signed by the doctor to indicate responsibility for the care as reflected in the recorded data.

Attention may now be focused on the development, implementation, maintenance and administration of the health information system within the hospital. The important procedures within the health record system include:

1. Record Numbering and Filing System

   The best method of numbering and filing health records is by a unit numbering and filing system. This requires that each patient is assigned a number on the first admission or attendance at a hospital. The number is retained by the patient and is used for each subsequent admission. In addition, all admissions are kept within one record folder and filed under this one number. If the procedure is automated, the computer program should

be designed to control the issuance of numbers by automatically assigning the next sequential number to a new patient on admission. The program should also allow for a search of the patient index to determine whether the patient already has an assigned number and thus prevent duplication.

2. Health Record Storage

   There must be sufficient space and equipment to store health records so that they are easily accessible when required. Regardless of the type of numbering and filing system used or whether the records are filed centrally or a decentralized system is maintained, there must be centralized authority.

3. Incomplete Record Procedure

   An incomplete health record control system, designed to ensure that all records of discharge patients are complete, should be maintained. This involves procedures to analyze the record to see that all relevant forms are present, in correct order, and that all entries reflect the minimum standards for good documentation practices.

4. Disease and Operation Coding

   A disease and operation coding and indexing system, designed to enable the organization of health care data for easy and meaningful retrieval, should be maintained. In most countries the International Classification of Diseases, Ninth Revision (ICD9) or the International Classification of Diseases, Ninth Revision Clinical Modification (ICD9CM) are used.

5. Health Care Statistics

   The procedure involves the collection, analysis, interpretation and presentation of monthly and yearly statistics, the prime source of which is the patients' medical records. When analyzed, these data reflect the professional work performed in the hospital and are used for decision making, to compare current operations with the past and as a guide in planning for the future.

6. Quality Assurance

   Hospital administrators must have access to information that is relevant, timely and accurate. Each individual health record should be seen as one element in the wider information system as it provides the decision support necessary for patient care.

A well designed and implemented health record management system can be used to:

1. Plan, monitor and control hospital services.
2. Measure resource utilization within the hospital.
3. Communicate with external authorities.
4. Support informed decisions on the management of the facility.

CHAPTER 3
SUMMARY OF ACTIVITIES

A. SOFTWARE AND HARDWARE NEEDS ASSESSMENT

The consultant started his activity after the hardware/software subcontract was signed. As a result, he can comment only on the adequacy of the purchased software and suggest future acquisitions. It is appropriate to first review the hardware configuration.

The company PT. Trimandiri Sempurna has been contracted to provide the hardware and software to the five hospitals participating in the interventions. The hospitals are:

1. R.S. Fatmawati
2. R.S. Persahabatan
3. R.S. Pasar Rebo
4. R.S. Hasan Sadikin
5. R.S. Tegalyoso

The first three are in Jakarta while R.S. Hasan Sadikin is in Bandung and R.S. Tegalyoso is in Klaten. The contractor's scope of work is to:

1. Install cabling system for LAN.
2. Install hardware.
3. Install the network system, operating system, and application software.
4. Test the equipment.
5. Maintain the installation for two years.

Each 386 server is equipped with:

1. One 1.2 MB, 5.25" disk drive
2. One 1.4 MB, 3.5" disk drive
3. Two 300 MB hard disks
4. One VGA monitor
5. One parallel and two serial ports
6. One network interface card
7. One keyboard

Each diskless 286 work station is equipped with:

1. One VGA monitor
2. One parallel and two serial ports
3. One network interface card
4. One keyboard

The peripherals to be attached to the network include:

1. One printer
2. One removable hard disk
3. One Uninterrupted Power Supply (UPS)

4. One voltage stabilizer

There are two basic system configurations that have been implemented. The first, at R.S. Fatmawati and R.S. Tegalyoso, includes the server, three workstations and two printers. At the remaining three hospitals the configuration specifies one server, one workstation and one printer.

The local area network software is Novell 2.2 with a linear Bus topology. DOS 5.0 is the operating system software. Word Perfect 5.0 and Lotus 3.0 are the applications software.

To prevent the loss of data, disk mirroring technology has been employed. This means the data are written to two hard drives simultaneously. The tape drive installed with each system then may be used for backup and archival purposes.

The present hardware/software contract provides DOS 5.0 operating system software and Novell 2.2 network software to each of the hospitals. Both systems are ubiquitous in Indonesia and local service is readily available. The software is also appropriate given the small initial size of the network and limited processing requirements. The 300 MB hard drive limits the amount of transactions that may be recorded. In all of the five hospitals the present system is capable of recording all inpatient transactions and perhaps several small outpatient activities. As the hospitals gain experience and devote more personnel to data processing activities the number of computers, size of server memory and hard drive capacity will need to be increased. The present DOS operating software is able to accommodate the improvements in hardware. If a large hospital with a heavy outpatient load such as R.S. Fatmawati decides to computerize their entire outpatient caseload, then a change to a minicomputer such as an IBM AS-400 might be warranted. There are numerous compatibility issues that are outside the scope of the consultancy. In either case the present software should serve a majority of hospitals well as they make the transition to Swadana status.

The word processing software Word Perfect 5.1 is widely available in Indonesia. The HSFP has used Word Perfect 5.1 as its standard word processing software. However, it is the consultant's experience, especially outside Jakarta, that most MOH offices use Wordstar. The type of word processing software eventually used by the hospital is not critical to the information system's effectiveness or success. Wordstar may easily be added to the network.

The Lotus spreadsheet software is the analytic software supplied under the hardware/software contract. This is an appropriate choice as most Indonesian computer analysts have experience with it.

At the present time the hardware and software provided as part of the hospital interventions adequately meet the needs of the hospitals. As greater demands are placed on the information system additional hardware will need to be added. As the data tracked by the information system become more detailed and cover several time periods, additional software may be needed. The information system generates a series of Dbase tables that are external to the compiled program. These tables provide the data to be used in any subsequent analyses. A database management program would be useful in preparing the data for further statistical analyses. DbaseIII or DbaseIV are widely available in Indonesia. If the hospital does not want to purchase such software, the data management portion of Lotus123 should be adequate. There are several excellent PC applications for project management such as TIMELINE from Symantic, MICROSOFT PROJECT, and SUPERPROJECT from Computer Associates. A statistics package would also be useful to the hospital. The consultant is partial to SAS from the SAS institute. However, SPSS is well known within Indonesia and is substantially less expensive.

B. CONCEPTUAL AND ACTUAL MODEL FOR SOFTWARE TO BE USED IN THE IMPLEMENTATION PROCESS

As of the end of August 1992 the software has yet to be used in any hospital. The Minister of Health opened the first Unit Swadana hospital (R.S. Tegalyoso) in Klaten, Central Java on August 4, 1992. He reviewed a working prototype of the system. The current implementation plan calls for software installation commencing during the first weeks of September.

The FoxPro financial, QA, and management information software are still undergoing slight modifications (fine-tuning) at the conclusion of the consultancy. The contents of the files, the structure of the databases and the appearance of data entry menus are the result of a collaborative effort between the subcontractors and the five hospitals undergoing the interventions. Consensus has been developed for the codes used within the system as well as the output report formats. While each hospital is given the choice of which clinical areas to collect data from, the content of the reports is driven by Department of Health reporting requirements. The desire to standardize on diagnosis, procedure, and tariff code make implementation of the interventions much easier. The components are described in great detail in a later section of the report.

The current software implementation strategy is to start with one hospital to fine-tune the software and develop the training manuals before moving onto the remaining four. R.S. Fatmawati has been chosen as the first hospital because of its proximity to the software contractor and the complexity of its operations. R.S. Fatmawati provides the basic tariff codes that are used within the information system. The financial staff seem quite capable of making the transition to the information system's financial module.

It is anticipated that the work with R.S. Fatmawati will take at least one month. The subcontractors have recently begun to coordinate their respective interventions to provide a constant message to hospital staff and minimize the impact of the initial training on hospital operations. The coordination is very important because the information system contains components provided by each of the other subcontractors. For instance, PQM has developed the relevant accounting codes and a Chart of Accounts.

During the training process it is anticipated that hospital staff will put "real" data into the system. This will allow the software contractor to further fine-tune the data entry screens if problems are identified. In addition, by participating with the hospital staff in the data entry process, the software contractor will better understand the procedures required to move the data from hospital ledgers, registers, and inpatient units to the computer. The firsthand experience may then be transferred into a more practical operating manual.

After the training at R.S. Fatmawati and the writing of the procedure manual have been completed, the software contractor will formally install the information system in the four remaining hospitals, the order of which will be determined through discussions among the other subcontractors and with the PIO/H office.

C. OUTLINE OF A STANDARD OPERATING MANUAL, STANDARD OPERATING PROCEDURES AND SOFTWARE OPERATORS SCOPE OF WORK

Because the information software is still being fine-tuned, the operating manuals and procedures have yet to be fully developed. The current strategy is to complete the documents based on experience gained during the training at R.S. Fatmawati. The training should commence during the first two weeks of September 1992. The software contractor is responsible for the development of information system's

operating manual. However, the completion of the other two documents should include input from the other subcontractors. For example, the MIS consultant is in the process of defining the flow of data within the hospital. The flow to a large extent determines the standard operating procedures involved in data entry into the information system. Likewise, another subcontractor is involved in developing training programs for management and financial personnel. This activity should be coordinated with the software coordinator to ensure consistency and reduce redundancy in the training efforts.

D. ANALYSIS OF THE DEVELOPED SOFTWARE AND RECOMMENDATIONS FOR THEIR FUTURE APPLICATIONS AND EXPANSION

The existing systems and application software supplied as part of the hospital interventions is appropriate to the level of training of the hospital personnel. As the hospitals become more familiar with the power of the information system, other uses of the data will become more apparent.

The current information system can track financial, quality assurance and management level data. It is seen as a tool facilitating the evolution towards greater hospital self-sufficiency. As the hospital becomes more facile in using financial and patient data in the decision making process, the demands on the information system will increase. Part of the increased demand is related to the collection of additional data, while part is related to the more sophisticated analysis of the existing data. The FoxPro-based information system must be modified in the former instance, while the acquisition of additional software will be required in the latter.

E. BRIEF REPORT ON PATENTS, SECURITY AND PREVENTIVE MEASURES AGAINST COMPUTER VIRUS

1. Patents

It is the understanding of the consultant that the MOH owns the information system's object code, while the software contractor retains the rights to the source code. The compiled FoxPro2 derived information system may be distributed by the MOH without infringing on the FoxPro copyright.

The information system has been designed to provide maximum flexibility in allowing hospitals to define financial and procedural codes appropriate to their requirements. However, if the MOH or the hospitals decides to modify the basic functions of the system they will need to purchase a version of FoxPro2 from an authorized distributor.

2. Information Security and Confidentiality

One of the most important and usually understated responsibilities of the information systems manager is that of managing information security and confidentiality. Unfortunately, this responsibility emerges generally as an afterthought of systems management. Indeed, in many environments, security access, confidentiality standards and related areas are given priority only after a problem has occurred. Systems security should cover the following functions:

1. User Access

   Complete description and definition of user categories and methods to provide access that will allow correct access and prevent inappropriate access.

2. Distribution of Information
   Policies, procedures, and operational methods to ensure that information distributed from the system is correct and in accordance with the organization's information dissemination policy.

3. Patient Confidentiality
   The development of policies, standards and routines that enforce the organization's responsibility to the patient with respect to confidential clinical information.

4. Access by Technical Staff
   The introduction and oversight of standards and procedures to confirm that system processing is protected from inadvertent or planned access by technical staff during system training, module implementation, or system testing.

5. Internal Controls
   The development of methods to comply with industry standards supporting the separation of duties, division of responsibilities and prevention of malicious behavior.

Security and confidentiality must be a collaborative effort involving both policy setting and operational groups within the facility. It is impossible to implement a set of security policies without the complete agreement and support by those users who will be most affected.

The user population must come to realize the significance and potential risk associated with health care information systems. The risk becomes compounded as health care organizations implement integrated information systems housing data and information across all functions of the organization. At the same time, the significance of potential risk is increasing tremendously as HIS's move from a financial systems orientation to the collection, maintenance, and management of the patient's clinical database.

The information system should include a set of utilities that seek to introduce a reasonable degree of security.

1. User-Based Security Access
   A utility that allows the user or user group to determine which menus and screens are available to them.

2. User Access Audit Log
   A utility for monitoring approved access and denied attempts.

3. Sensitive Transaction Update Log.
   A utility for tracking the updating of sensitive transactions by user and date.

4. Separate Data Processing, Testing, and Training Environments
   The ability to provide a discrete data processing environment that is not utilized for testing or training purposes.

5. Function Access Control
   A utility for restricting access to certain applications of functions by location and/or time period.

6. Standard Application Module Termination
   A utility for standardizing the exit method for an application module so that the system can be utilized in conjunction with modems and data-only telephone systems.

7. Identification of Confidential Patients
   The ability to identify certain patients as confidential patients and restrict all information regarding these patients to certain functions.

8. Controlled Access by External Sources
   The ability to limit access to certain patient information to those individuals approved in advance. This is important when providing physician access networks so that the physicians are restricted to reviewing information only on those patients whose cases they are treating.

3. Computer Virus

The same measures taken to secure confidentiality of financial and medical records work to reduce the risk of computer virus. CENTRAL POINT ANTIVIRUS, NORTON ANTIVIRUS, and McAFEE SCAN all provide excellent virus protection. Boot sector viruses are a particular problem in Indonesia. All the programs may be activated as part of the computer's startup procedure to protect against such viruses. McAFEE Scan Version 8.4B89 has been installed as part of the information system. It is recommended that the hospitals establish contact with the Singapore distributor to ensure the timely acquisition of updated versions.

F. STRATEGIES FOR SOFTWARE SUSTAINABILITY AND TECHNOLOGY TRANSFER IN THE FUTURE

To the extent that the Unit Swadana process encourages the demand for accurate and timely data, the present efforts will be sustainable and will grow. The involvement of MOH personnel at the central and hospital level is the key strategy ensuring the activity's sustainability. The need for the information system and a general consensus concerning its capabilities has already been designed into the system.

The maintenance of the information system requires resources. The resources involve continued personnel training as well as the routine maintenance of the system hardware. The process of becoming self-sufficient will take time. During the interim the hospitals will need additional outside funding to maintain the hardware and the developing skills of the systems operators and managers. The funds may come from either the central or provincial levels as part of the training and maintenance portions of the Routine Operating Budget. Hospital managers must request and then allocate the resources needed to maintain the system. If the demand does not exist within the hospital then it is probably not appropriate to install an information system.

Adding additional hardware and software to other hospitals wishing to participate in the early stages of Unit Swadana will require outside funding. If the MOH at the central level cannot provide the funds, it is recommended that donor organizations be contacted. Currently, the Asian Development Bank (ADB) is engaged in providing computer hardware to several government hospitals. The MOH should explore ways to incorporate the results of the hospital interventions with the hardware being provided by the ADB to create a more powerful information system.

CHAPTER 4
THE QUALITY ASSURANCE AND MEDICAL BILLING SYSTEMS

The main quality assurance menu provides 11 options. Seven are for data entry, one for report generation, one for system maintenance, and two for exiting the system. Each of the menu selections may have its access restricted to users with the appropriate authorizations. The authorizations will be defined by the hospital's Director prior to the initiation of the system.

DEPKES INDONESIA
Main Menu

1. Entri Registrasi Pasien Rawat Nginap
2. Entri Data Pasien Rawat Nginap
3. Entri Mutasi Pasien / Pindah
4. Entri Transaksi Pelayanan
5. Entri Data Karyawan RS
6. Entri Data Tabel
7. Inisialisasi Data Rumah Sakit
8. Menu Laporan
U. Utilitas
S. Selesai Menggunakan
X. Kembali Ke DOS

Selection of the Inpatient Registration Option One changes the screen to the inpatient registration file. The file contains variables such as registration number admission date, medical record number, the admission type, admission status, and the patient's name. There are buttons on the bottom of the screen that allow the operator to search the registration file, delete a record, or return to the main menu. Double clicking the screen causes the patient registration data entry screen to appear (see screen below). The buttons on the bottom of the screen allow the operator to move within the registration database. Searches may be performed. In addition, the operator may click the Diagnosis and Tindakan box or the Patient Data box to move to additional screens.

Registrasi Pasien Rawat Nginap
No. Reg.
No. CM. Dirawat Ke
Nama Pasien Sex
Tgl. Lahir - - Alamat
Prosedur Masuk RS
Dikirim Oleh
Bagian/UPF
Bangsal Kelas
Tgl. Masuk - - Jam : Umur Saat Masuk ---
Tgl. Keluar - - Jam : Lama Dirawat --- Hari
Sebab Dirawat
Dr. Jaga (NIP/NRP) NIP.
Keadaan Keluar
Cara Keluar
Dokter (NIP/NRP) NIP.
Cara Pembayaran
Jaminan Kantor
[ ] Diagnosa & Tindakan
[ ] Data Pasien

® New ¯ ® Save ¯ <Cance> <Cari> <Prev> <Next>

The inpatient Diagnosis and Procedure input screen allows the operator to enter information concerning the patient's diagnoses, complications, and other sicknesses. In addition, data concerning nosacomial infections, transfusions and other procedures are recorded. Some of the data collected from this screen are used to complete the RL series of forms. The Diagnosis fields are linked to a table of diagnosis. The codes for the diagnoses are from the International Classification of Disease (ICD) system.

Registrasi Pasien Rawat Nginap
Diagnosa & Tindakan

Diagnosa Utama 1
Diagnosa Utama 2
Komplikasi 1
Komplikasi 2
Penyakit Lain 1
Penyakit Lain 2
Penyebab Luar Cedera
Tindakan 1
Tindakan 2
Infeksi Nosokomial
Penyebab IN
Transfusi Darah cc
Radioterapi

Catatan

At present this and all the other information system screens will be entered at the time of discharge.

The patient data screen records data in congruence with Department of Health inpatient reporting guidelines. The information provides the basis for the medical record and is searched during the assignment of a medical record during registration process. There is also a box that when clicked allows the operator to enter the presence of different types of immunizations.

The next choice on the main menu (option 2) list is for entry of inpatient data. The inpatient data screen that first appears lists the medical record number, patient name, birth date and sex. The file may be searched by each of these variables in order to determine if the patient has a previous medical record number. Double clicking any of the records opens up the inpatient data screen that is also accessible through the patient registration entry selection from the

No. CM.
Nama Pasien Sex (L/P)
Alamat
Kelurahan RT/RW /
Kecamatan Kabupaten/Kodya
No. KTP/SIM No. Telepon ( )-
Suku Bangsa Agama
Tgl. Lahir - - Umur --- Status Kawin
Pendidikan
Pekerjaan H.I. (Y/T)
KELUARGA TERDEKAT:
1. Nama No. Telp
Alamat ( )-

2. Nama Umur ( ) Ayah
Pekerjaan ( ) Suami

3. Nama Umur ( ) Ibu
Pekerjaan ( ) Isteri

main menu. This option may also be selected from the inpatient registration menu.

The third entry on the main menu allows the operator to enter the dates if and when the patient changes the class of the hospital room he or she is staying in. It is important to know the class of room occupied as this provides the basis for subsequent hospital charges. In the Ministry of Health's list of service charges a given procedure has different charges based on the class of the room the patient is staying in. For instance, a person receiving an injection while staying in a VIP room will be charged more than a person receiving the same injection in a third class room. The screen shows that database containing registration, medical record, patient name, and the date and the time that the change in room status occurred. The time is important as each hospital has different cutoff points when determining room charges. As in all of the previous displays of different databases, a double click places the operator in the data entry screen.

```
                    Pasien Pindah Intern

      No. Registrasi    00000024
      No. CM.       00000006
      Nama Pasien   Angelina
      Tanggal 24-07-1992   Jam 11:32
      DARI: Bangsal 02 Mawar        Kelas VIP
      KE:  Bangsal 01 Melati        Kelas VIP

      ® New ¯ ® Save ¯ <Cance> <Delet> < Rights > <Prev>
<Nex>
```

The fourth option on the main menu is the data entry of transactions. This is the heart of the billing system. The selection of this option is followed by a request to state the period during which the transaction occurred. The operator is requested to input the patient's registration number, the date of the transaction and the record number of the transaction. The number of the transaction may then be used internally as part of the financial system. The operator then inputs the code of the service provided. If the code en' ed is incorrect the program prompts the operator to search the transaction file for the correct code. This is accomplished by pushing the page down button and then scrolling until the desired service is highlighted.

```
                    Transaksi Pelayanan

      Periode 1992/08  No. Register        No. CM
      Nama Pasien
      Kelas            Bangsal
      Cara Pembayaran

      Tanggal  Kode Pelayanan      Deskripsi      Harga     Qty
To

      [X] Tampilkan Yang Sudah Ditagih    Jumlah Transaksi   0
Total
                  <Sblm>  <Brkt>  <Mula>  <Akhir
```

The fifth main menu option is related to the hospital's personnel. When this option is chosen the operator is presented with the data entry screen for several different files. In addition to general background information the operator has access to four additional screens. The screens accept data entry concerning the employee's education, past employment history, civil servant class, and special course work.

Data Individual Ketenagaan Rumah Sakit

DATA PRIBADI :
Nama Drs. Rina Sutomo
Tempat, Tgl.Lahir Jakarta ,13-03-1954
Jenis Kelamin (1/2) 2 Perempuan Status Perkawinan 2 Belum
Agama 1 Islam
No. Induk (NIP/NRP) NIP 789000012
Instansi Induk 86 Yayasan Sosial
Status Pegawai 1 PNS Pusat (Depkes)

DATA PEKERJAAN DI RUMAH SAKIT :
Status Ketenagaan 1 Tenaga Tetap
Jabatan Struktural
Terhitung (TMT) 12-12-1986
No. SK/Tgl. SK 86/ABC/12345 /01-12-1986
Jabatan Fungsional 4.09 Sarjana Akutansi
Bidang Tugas

[ ] Pengangkatan [ ] Pendidikan Lanjutan
[ ] Latihan Jabatan/Kursus [ ] Pengalaman Kerja

Pendidikan Lanjutan

Ijazah
Nama Sekolah/Akademi/Universitas
Tahun Selesai

® New ¯ <Delet> ® Save ¯ <Cance> < Rights > <Prev>

The screen to the left allows the operator to enter data concerning the employee's education.

The screen below allows the operator to enter information concerning any special courses the employee may have attended. As hospitals become more complex in their operations, personnel officers will need to know the skills of the employees. In addition to being used to determine who might be eligible for additional training, this information is tied into the payroll function.

Latihan Jabatan/Kursus

Nama Latihan Jabatan/Kursus
Lamanya (dalam Jam) 0
Tahun Selesai
Dalam Negeri/Luar Negeri (DN/LN)

® New ¯ <Delet> ® Save ¯ <Cance> < Rights > <Prev>

Pengangkatan Karyawan RS

PENGANGKATAN PERTAMA
Pangkat
Terhitung (TMT) - -
No.SK/Tgl SK.
Ijazah/Tahun
Nama Sekolah
Pangkat Sekarang
Terhitung (TMT) - -
No.SK/Tgl SK.
Masa kerja golongan (Thn/Bln) **/ 8
Instansi yang membayar gaji

® Ok ¯

Within the Indonesian civil service there are numerous different levels. These in part are determined by experience and academic credentials. In addition, the amount of time spent at each level determines the salary of the employee. The screen to the left records such information.

The sixth main menu selection allows access to the data entry tables. The tables are used throughout the data entry process. For instance, during the registration process the operator must key in if the patient's employer has an arrangement with the hospital to cover payment for services. There is a table listing the International Classification of Disease (ICD) that is drawn on when the diagnosis is being keyed into the diagnosis file.

DEPKES INDONESIA
Entry Data Tabel

1. Bangsal/Ruang
2. Diagnosa/ICD
3. Tindakan/Operasi
4. Jaminan Kantor
5. Jabatan Fungsional Karyawan
6. Instansi Induk Karyawan RS
7. Pangkat Karyawan Rumah Saki
8. Status Penyelenggara RS

Tabel Tindakan

Kode Tindak 5-010
Deskripsi Pungsi tengkorak (kranium)

® New ¯ <Delet> ® Save ¯ <Cance> < Rights > <Prev> <Next>

The selection of any of the options of the data entry menu reveals a series of similar screens. The set of files accessed through this menu provides the hospital with the flexibility to adjust the information system to its specific needs. For instance, the procedure file (tindakan) allows the hospital to record all the procedures that may be performed at the hospital. Needless to say, this will vary across hospitals.

The screen below allows the hospital to enter the codes for the types of organizations that provide manpower to the hospital. As has been previously discussed, one of the main benefits of the information system is the standardization of procedures and codes. The standardization allows

Tabel Instansi Induk

Instansi Induk 01
Deskripsi Dep. Dalam Negeri

aggregation of hospital statistics for Ministry of Health analyses. In addition, with standard definitions the hospitals will be able to compare their performance to similar hospitals.

The screen below allows the hospital to enter the various manpower codes required by the Ministry of Health. The list of categories and codes corresponds to those required to complete the RL series reporting forms.

```
Tabel Profesi

Kode Profesi 1.
Deskripsi   TENAGA MEDIK
```

The ICD table allows the hospital to enter the ICD codes and their description. There are over 14,000 codes in the latest ICD manual. The inclusion of all the codes might not be appropriate for some of the smaller hospitals. There is a need for further discussions with the IDI on the codes that are appropriate to include.

```
Tabel ICD

Kode ICD  002
Deskripsi  Typhoid And Paratyphoid  Fever

® New ¯ <Delet> ® Save ¯ <Cance> < Rights > <Prev>
<Next
```

The screen below allows the hospital to enter the type of hospital that it is.

```
Tabel Penyelenggara RS

Kode Status 10
Deskripsi  Departemen Kesehatan

® New ¯ <Delet> ® Save ¯ <Cance> < Rights > <Prev>
<Next>
```

The screen below contains a listing of the personnel codes that are currently used by the Ministry of Health.

```
Tabel Pangkat

Kode Pangkat 01
Deskripsi   Prada

® New ¯ <Delet> ® Save ¯ <Cance> < Rights > <Prev>
<Next>
```

```
Tabel Bangsal

Kode Bangsal 01
Deskripsi   Melati
          VIP   I   II  IIIA  IIIB  Total
Jumlah TT   10  12  12   12    12    58

® New ¯ <Delet> ® Save ¯ <Cance> < Rights > <Prev>
<Next>
```

The Bangsal table allows the hospital to enter information about the number and types of beds that are present in a hospital ward.

Finally, the last screen provides the list of companies that the hospital has payment arrangements with. This information can then be tied into the billing and financial systems. The file may also contain information on any JPKM provider that has an association with the hospital.

```
Tabel Jaminan Kantor

Kode Kantor 001
Nama Kantor PT BERSAMA

® New ¯ <Delet> ® Save ¯ <Cance> < Rights > <Prev>
```

```
DEPKES INDONESIA

Inisialisasi Data Rumah

1. Data Inventarisasi RS
2. Tarip Pelayanana RS
```

The seventh main menu choice contains two files relating to the hospital. The first one covers the hospital's physical plant. The address and name of the hospital's administrator are recorded. There are two further selections corresponding to the number of inpatient beds and outpatient clinics. The inpatient bed file contains data on the number of beds in each class within each functional unit of the hospital. The outpatient department file lists the number of hospital outpatient departments and the number of days that they are open each week. The physical plant files are important in providing data that goes into the creation of the RL forms required by the Department of Health. The second set of files is related to the tariffs charged by the hospital. The 16 types of services are listed. The operator selects the tariff type that is to be changed or added to. Once the category is chosen the operator may enter the code, description, and charge information of a new service. The operator may use the "Prev" or "Next" options to scroll through the existing file until the desired service is reached.

```
Data Inventarisasi RS

1. Kode RS        3310015
2. Nama RS        RSU Tegalyoso
3. Jenis RS       A  RS Umum
4. Kelas RS       C
5. Nama Direktur  Dr. Sulaeman
6. Alamat RS      Jl. Dr. Soeradji Klaten
   Telepon        (0272)-21104
7. Kegiatan Dimulai 01-01-1970
8. Surat Izin/Penetapan :
   a. Nomor       123/Yan.Kes/RS/70
   b. Tanggal     31-12-1969
   c. Oleh        Menkes RI
   d. Sifat (1/2) 2  Tetap
9. Penyelenggara RS :
   a. Nama        Departemen Kesehatan RI
   b. Status      10 Departemen Kesehatan
10. Fasilitas Kesehatan Gigi :
   a. Kursi Gigi  2   b. Unit Gigi  2

11. [X] Fasilitas TT Rawat Nginap
12. [X] Fasilitas Unit Rawat Jalan
```

The screen below allows the operator to enter the number and types of inpatient beds included in the hospital functional unit. As more data is collected this information may be used in the estimation of unit costs.

```
        Fasilitas TT Ruang Rawat Inap
Kode UPF   01
Deskripsi  Penyakit Dalam

        VIP   I   II  IIIA  IIIB  Total  Luas Ruang
Jumlah TT   6   10   10   20   20    66      0 M2

® New ¯ <Delet> ® Save ¯ <Cance> < Rights > <Prev> <Next>
```

Likewise, the screen below provides outpatient data in terms of the number of outpatient clinics and the number of days that they are open during the week.

```
        Fasilitas Unit Rawat Jalan

Kode Unit        01
Deskripsi
Hari Buka Perminggu  0

® New ¯ <Delet> ® Save ¯ <Cance> < Rights > <Prev> <Next>
```

The next screen is the heart of the billing system. The charges have been organized into categories suggested by the R.S. Fatmawati tariff codes. The operator selects one of the categories and a list of the items within that category appears.

For instance, if the operator wanted to add or change the charge of a given outpatient service he or she would select the first menu option and the following screen would appear.

```
DEPKES INDONESIA
Tarip Pelayanan

1. Tarip Karcis Rawat Jalan
2. Tarip Rawat Nginap
3. Tarip Jasa Medik Visite/Konsultasi
4. Tarip Pemeriksaan Laboratorium Klinik
5. Tarip Pemeriksaan Laboratorium Patologi Anatomi
6. Tarip Pemeriksaan Radio Diagnostik
7. Tarip Pemeriksaan Diagnostik Elektromedik
8. Tarip Pemeriksaan Diagnostik Non Elektromedik
9. Tarip Tindakan Bedah Kecil DiLuar Kamar Operasi
A. Tarip Persalinan
B. Tarip Tindakan Medik (Medical Intervention)
C. Tarip Tindakan Bedah DiKamar Operasi
D. Tarip Tindakan Rehabilitasi Medik
E. Tarip Prosthetic Orthetic
F. Tarip Konsultasi
G. Tarip Perawatan Jenazah
```

A similar screen would appear after the selection of any of the menu items.

```
Tarip Karcis Rawat Jalan
Kode Pelayanan 01.02
Deskripsi    Karcis Gawat Darurat
Tipe
Kode Bangsal  01 Melati          Kelas

  Bahan/Alat    Jasa RS    Jasa Medik    Total
      0         1,000        0          1,000

® New ¯ <Delet> ® Save ¯ <Cancel> < Rights > <Prev> <Next>
```

DEPKES INDONESIA
Menu Laporan

1. Laporan Tagihan (Billing)
2. Laporan RL
3. Laporan Register
4. Laporan Tabel
E. Edit Definisi Laporan

The eighth option of the main menu contains listings of the reports that may be generated by the information system. There are a series of reports associated with the patient's bill. The reports currently required by the Department of Health are included in the RL section. The registration reports process data from the registration files to report inpatient census and utilization statistics. There is also the option to report on the contents of the files that are used throughout the information system. The output here corresponds with the tables found in the data entry series of screens. Finally, there is a section that will allow the operator to edit the contents of any report that is generated by the system.

DEPKES INDONESIA
Menu Laporan Tagihan (Billing)

1. Ringkasan Biaya Rawat Nginap
2. Perincian Biaya Rawat Nginap
3. Cetak Ulang Ringkasan Biaya Rawat Nginap
4. Cetak Ulang Perincian Biaya Rawat Nginap
5. Biaya Rawat Nginap (Periodik)
6. Perincian Biaya Rawat Nginap (Periodik)
7. Pasien Rencana Pulang

The billing selection allows the operator to produce a series of reports indicating the amount that the patient has paid up to a certain period of time, the amount billed over a specified period of time or the amount of the entire bill. In addition, the operator may also specify the amount of detail to be included in the billing statement.

Laporan Ringkasan Biaya Rawat Nginap

Periode 9208
Nomor Register
Tanggal Pencetakan 09-08-1992
Nama yang mencetak
® Process < Cancel >

The screen on the left allows the operator to specify the time period for which to provide summary billing information. In this case the period is in months.

DEPKES INDONESIA
Menu Laporan RL

1. RL 1 - Data Kegiatan Rumah Sakit
2. RL 2a - Data Keadaan Morbiditas Pasien RN. RS
3. RL 3 - Data Inventarisasi Rumah Sakit
4. RL 4 - Data Keadaan Ketenagaan Rumah Sakit
5. RL 4 - Perincian Dokter Pasca Sarjana
6. RL 4 - Ketenagaan Menurut Jenis & Golongan

The next menu reveals the different RL forms that the operator may request. The printouts have been designed to resemble Ministry of Health form, thereby reducing the hospital's efforts in meeting Ministry of Health reporting requirements.

Likewise, there are a set of reports that are derived from different hospital inpatient registers.

DEPKES INDONESIA
Menu Laporan Register

1. REG 3 - Pendaftaran Pasien Rawat Nginap (RN)
2. REG 4 - Pelayanan Pasien Rawat Nginap
3. Sensus Harian Pasien Rawat Nginap
4. RP 1a - Sensus Harian Pasien Rawat Nginap
5. RP 2 - Rekapitulasi Sensus Harian Pasien RN
6. RP 1 - Rekapitulasi Harian Pasien RN

If the hospital wants a hard copy of the contents of the files that it had entered under the data entry menu, the operator may use the following menu to select the file to print.

DEPKES INDONESIA
Menu Laporan Tabel

1. Tabel Diagnosa
2. Tabel Tindakan
3. Tabel UPF
4. Tabel Ruang/Bangsal
5. Tabel Tarif Pelayanan/Tindakan
6. Tabel Jaminan Kantor
7. Tabel Instansi Induk
8. Tabel Jabatan Fungsional/Profesi
9. Tabel Pangkat Karyawan RS

DEPKES INDONESIA
Menu Utilitas

1. Mengubah Kata Sandi
2. Daftar Pemakai Komputer
3. Set Wewenang Khusus
4. Lokasi File Aplikasi
5. Lokasi File Sistem
6. Indexing File
7. Packing File
8. Set Sistem Variable
F. FoxPro Command

The Utility option of the main menu contains a series of screens that are associated with system maintenance. The first three options are associated with the security of the system. Each user is recorded along with his or her password and various authorities. Each screen of the information system has an authority level associated with it. If the operator does not have that authority then he or she may not access the screen. In addition, there are a set of authorities associated with data entry and the ability to delete files. The location of the various files used by the information system is included along global system settings.

The operator may enter his or her name and password. There will be a second screen that prompts for the new password followed by another to reconfirm the change.

```
Change User Password

User Name  : KEN
Description: PINHEAD

Please type your old Password.
Password  :
```

```
DEPKES INDONESIA
Setting Authorization (Alt-P)

1. Master User
2. Edit Wewenang Pemakai
3. Edit Daftar Pemakai
4. Edit Definisi Menu
5. Buat Definisi Help
6. Edit Definisi Help
7. Edit Program
```

The screen to the left allows the operator to set the authorization levels for each of the data entry and viewing screens. Usually only the head of the information system and the hospital director would have access to all the screens.

```
Lokasi File Aplikasi

FDATARS  File Data Inventarisasi RS
FIPD     File Pasien Rawat Inap
FREGIPD  File Registrasi Pasien Rawat Inap
FMUTASI  File Mutasi Pasien Rawat Inap
FTP0000  File Transaksi Pelayanan
FKARYRS  File Karyawan
FLATIH   File Latihan Karyawan
FPGLM    File Pengalaman Kerja Karyawan
FPDKL    File Pendidikan Lanjut Karyawan

[ ] File Tabel

® Simpan ¯   < Batal >
```

The application file menu lists the names of the files that are used in the information system. These are the actual file names that hold the data that was entered as part of the hospital admission procedure and recording of the daily transactions. These are the raw files that may be used by the hospital for any subsequent statistical or financial analyses.

The file location menu lists the names of the table files that are used by the information system.

Many of the files are those that were entered from the data entry menus recording the codes that the information system uses.

```
Lokasi File Tabel

FTUPF    File Unit Pelayanan Fungsional
FTURJ    File Unit Rawat Jalan
FTBGSAL  File Bangsal/Ruang
FTDIAG   File Diagnosa/ICD
FTARIP   File Tarip Pelayanan
FTTINDAK File Tindakan/Operasi
FTSTRS   File Status Penyelenggara RS
FTKANTOR File Jaminan Kantor
FTJABAT  File Jabatan Karyawan RS
FTINDUK  File Instansi Induk
FTPROF   File Profesi Karyawan
FTPGT    File Pangkat Karyawan
FNOMOR   File Nomor Urut
```

In a similar fashion, the screen below indicates the location of other system files.

```
System Files Location

FSMENU  File Menu Definitions          lib\
FSID    File User List                 lib\
FSOTOR  File Authorization             lib\
FSHELP  File Help Description          lib\
FSRDEF  File Report / Process Definitions lib\
FSMEMO  File Message / Memo            lib\
FSCRREP File Report Output             lib\
FSINFO  File System Informations       lib\
```

The FoxPro2 program attains the rapid sorting of observations through the use of an indexing system. As more files are added to the information system the indexes must periodically be updated.

```
DEPKES INDONESIA
  Indexing File

1. File Aplikasi
2. File Tabel
3. File Control System
```

Selection of the first two menu options reveals the lower two screens.

DEPKES INDONESIA
Indexing File Aplikasi 1

1. File Pasien Rawat Inap
2. File Registrasi Pasien Rawat Inap
3. File Transaksi Pelayanan
4. File Mutasi Pasien / Pindah Intern
5. File Karyawan
6. File Latihan Jabatan/Kursus
7. File Pendidikan Lanjutan
8. File Pengalaman Kerja

DEPKES INDONESIA
Indexing File Tabel

1. File Tarip Pelayanan
2. File UPF
3. File Bangsal/Ruang
4. File Diagnosa/ICD
5. File Tindakan / Operasi
6. File Jaminan Kantor
7. File Jabatan Fungsional Karyawan
8. File Pangkat Karyawan RS
9. File Nomor Urut

The files listed here contain all the data recorded by the information system. Their locations were noted in the previous selection.

The files containing system control data may also be indexed based on the selections in the menu to the right.

DEPKES INDONESIA
Indexing File Control System

1. File Menu Definition
2. File User List
3. File User Authorization
4. File Help Information
5. File Report Output

In addition to the reindexing of files, data must periodically be deleted from the data base. The deletions may be the result of erroneous entry or part of the backup system. The menus follow the same general patterns as found in the indexing set of screens.

DEPKES INDONESIA
Packing File

1. File Aplikasi
2. File Tabel
3. File Control System

DEPKES INDONESIA
Packing File Tabel

1. File Tarip Pelayanan
2. File UPF
3. File Bangsal/Ruang
4. File Diagnosa/ICD
5. File Tindakan / Operasi
6. File Jaminan Kantor
7. File Jabatan Karyawan RS
8. File Nomor Urut

The screens follow the same pattern as before:

```
DEPKES INDONESIA

Packing File Control System

1. File Menu Definition
2. File User List
3. File User Authorization
4. File Help Information
5. File Report Output
```

```
DEPKES INDONESIA
Packing File Aplikasi

1. File Pasien Rawat Inap
2. File Registrasi Pasien Rawat Inap
3. File Transaksi Pelayanan
4. File Mutasi Pasien / Pindahan
5. File Karyawan
6. File Latihan Jabatan/Kursus
7. File Pendidikan Lanjutan
8. File Pengalaman Kerja
```

Finally, there is a menu that allows the operator to set the system parameters. Entries to this menu will change the titles of the main screens, the color of the screen and whether some of the system commands appear in Indonesian or English.

```
System Definition

Application     Too Fast Too Soon
Client name     I Am Having Fun
Access Code     2249
Multi User      Y
Default         Printer         SCREEN
Temp:F:62095619.TMP
Default Color   ( ) Color ( ) Mono  ( ) B & W
Main Menu Name  MENUMAIN
Language        ( ) English   ( ) Indonesia

Account Code
 Picture     ##.#.##.#
 Blank field  . . .

        ® Save ¯   < Cancel >
```

CHAPTER 5
THE FINANCIAL COMPONENT OF THE HEALTH INFORMATION SYSTEM

The accounting/financial package opens with a screen similar to the quality assurance and management information system module. The menu system was designed to resemble the QA/MIS module to simplify training between the two modules. A system operator for one module, then, will be familiar with the other and be able to make further modifications without additional training.

```
| RS Tegalyoso |
+-----------------------------------------
+--------------Otorisasi Pemakai---
|      Nama Pemakai:          |
|      Kata Sandi :           |
|      Keterangan :           |
+-----------------------------------------
+-----------------------------------------------+
|      Sistem Akunting versi 3                  |
|  Copyrights (c) 1990-1992 Marcelinus Gozali   |
|      PT. Inti Inforama Sejahtera              |
|     Jl. Cideng Barat No. 87 - Lantai 3        |
|     Jakarta Barat (10150) - Indonesia         |
|  Telp: (021) 384-7797  Fax: (021) 384-7801    |
+-----------------------------------------------+
```

After the users name and password are entered into the computer the main menu is displayed.

```
RS Tegalyoso
Menu Utama
----------------------
1. Transaksi G/L
2. Proses
3. File
4. Cetak Laporan
U. Utilitas
S.Selesai
Q. Quit to DOS
```

The main menu reveals seven choices. The first one is the main entry set of screens that are based on the general ledger. The second selection provides a set of screens associated with files within the general ledger and are used to update the information. The file selection allows the user to view the various files and the definitions contained within them. The report selection provides a set of screens requesting information on the type of report desired and the time period to be summarized. As in the QA/MIS package there are selections for systems utilities, user logoff and returning to the DOS prompt.

Each data entry and viewing screen has a set of authorities associated with it that allows that the hospital director to determine who has access to the screens. The levels of authority are defined through the utility selection in the same manner as in the QA/MIS module.

Choice of the transaction option reveals a menu with two additional choices. The first selection is for the entry of the daily transactions. The second one allows printing of the transactions after the original data entry.

```
RS Tegalyoso
Menu Transaksi
-----------------------------
1. Entri Transaksi
2. Cetak Transaksi
-----------------------------
Pilih dengan
Option:1
```

```
-------------File Saldo Buku Tambahan---------

Akses File untuk Data Periode ¦ Agustus ¦

                    « OK »
```

The selection of the daily entry option then prompts the user to specify the time period during which the transaction occurred. The user must select both the month and the year. By pushing the "page down"button while either the month or the year field is selected a pop up list of years or months appears on the screen and the user may choose among them. Of course, the user may enter the month and year directly.

After the user selects the time period of the transaction, the transaction screen appears. The operator must enter the code of the transaction and the number of the transaction form that provides the hard copy. In addition, the operator must key in the date of the transaction, date of data entry and his or her number. The operator then enters the account and the sub account number with which the transaction is associated.

```
Periode:08-92          RS Tegalyoso          Tgl:17-08-92
+-------------------------------------------------------------------
¦ Perusahaan 01                                          ¦
¦ Kode Sumber        Tgl.Transaksi        Tempo      Operator
¦ No.Voucher          Tgl.Entri            Batch       Proses
¦
+-------------------------------------------------------------------
¦ No.Akun ¦ Sub ¦       Keterangan       ¦ No.Dokument ¦D/K¦
Jumlah
```

The operator then enters a description of the transaction and the debits or credits the selected account. The program then allocates the transaction to the appropriate accounts and informs the operator if the debit equals the credit. This ensures that the entry is balanced.

The user may then return to the previous menu. If the user needs to change a transaction he or she may select the option from the menu. The user must then enter the batch code and the account code.

```
---------Cetak Transaksi Harian---------

Kode Batch
Kode Sumber
Tanggal Entri 17-08-1992 s/d 17-08-

    « Proses »  < Batal >
```

The user may then return to the main menu and choose to process the period's transactions. The operator is then provided four different options. The first one allows the operator to post the transactions associated with a specified time period. The second option provides a listing of the

```
RS Tegalyoso
Menu Proses
-----------------------------
1. Posting Transaksi
2. Hitung Total Buku
3. Menu Proses Akhir
4. Menu Proses Akhir
-----------------------------
Pilih dengan
Option:2
```

chart of accounts. The remaining two options process transactions for monthly or yearly reporting periods.

The selection of posting option then prompts the operator with the lower screen.

The operator then fills in the appropriate dates and presses the process button.

```
--------------------Posting Jurnal--------------------

Proses untuk Tanggal Entri     19-08-1992 s/d 19-
08-

        « Proses »  < Batal >
```

In a similar fashion the operator is prompted for a range of dates after selection of additional process menu items.

The next item on the main menu is the files option.

```
RS Tegalyoso
Menu File
-----------------------------------
1.Entri & Koreksi File
2.Cetak Daftar
3.Entri & Koreksi Definisi
-----------------------------------
Pilih dengan
Option:3
```

The three selections allow the operator to enter and change file data, change reports and define the contents of current or future reports.

The choice of the first menu option reveals the following screen.

```
RS Tegalyoso
Menu Entri & Koreksi File
-------------------------------
1. Kode Perkiraan Buku Besar
2. Saldo Buku Besar
3. Kode Buku Tambahan
4. Saldo Buku Tambahan
5.        Saldo        Perincian
No.Dokument
-------------------------------
Pilih dengan
Option:31
```

The five files listed provide the basis of the accounting system.

The files are based on the General Ledger, associated sub-ledgers and accounts, and the overall hospital balance sheet. The fifth selection references the document numbers of the various invoices tracked by the accounting system. The invoice numbers are needed for later audit processes.

Kode	Nama Perkiraan	TL	TJ	BT	Dok Inv
1	Aktiva	1		T	
11	Kas	2		T	
111	Kas Kecil	3		J	
112	Kas Dana DIK	3		J	
113	Kas Dana DIP	3		J	
114	Kas Dana Khusus	3		J	
12	Bank	2		T	
121	Bank A	3		J	
122	Bank B	3		J	
123	Bank C	3		J	
124	Bank D	3		J	

The selection of the codes from the general ledger lists the file containing all the account codes. The various columns (general ledger, detailed ledger, balance sheet, and document number) indicate where the files may be found.

The selection of the balance sheet option reveals the balance of a series of accounts which may be specified by the operator. The operator is given the options of searching for, entering or deleting accounts.

File Saldo Perkiraan Buku Besar

Tahun	Kode	Nama Perkiraan	Saldo Akhir Bln:08
1992	1	Aktiva	1,470,000.00
1992	13	Piutang	1,470,000.00
1992	133	Piutang Jaminan Perusahaan (Kontrakt	1,470,000.00
1992	3	Dana (Equity)	0.00
1992	36	Saldo Surplus/Defisit	0.00
1992	362	Saldo Hasil Usaha Tahun Berjalan	0.00
1992	998	Ikhtisar Rugi/Laba	0.00

« Cari » < Hapus > < Tamat >

The selection of the file code book allows the operator to add new accounts. The type of account column corresponds to the BT column in the general ledger file.

To add more information on a given account the operator selects the "Entri Judal" button.

File Daftar Kode Buku Tambahan

Tipe	Judul Buku Tambahan
C	Daftar Pelanggan
D	Departmen
M	Mata Anggaran Pengeluaran
P	Mata Anggaran Penerimaan
S	Daftar Supplier

Kode	Nama Buku Tambahan
0001	PT. Maju Jaya
0002	PT. Trijasa
0003	PT. Inti Inforama Sejahtera
0004	PT. PQM
0005	PT. Trimandiri

<Entri Judul> <Entri Kode>

The selection then provides the following screen listing the name of the supplier.

```
        File Daftar Judul Buku Tambahan
Tipe      C
Judul B.T.  Daftar Pelanggan
Nama Atribut Nama Perusahaan
        [X] Simpan Data Alamat

<Entri> <Hapus> «Simpan» <Batal> <Wewenang> <Sblm>
```

The selection of the address information option reveals the following screen.

```
            Daftar Pelanggan
Tipe B.T.     C
Kode B.T.     0001
Nama Perusahaan PT. Maju Jaya
Alamat        Jl. Rawa Belong 10
          Jakarta

Keterangan 1
       2
Wakil Kontak              Telepon
                            ( ) -
```

The screen allows additional data to be added to the list of suppliers

Returning to the main file sub-menu and selecting the balance of accounts option prompts the operator to enter the year in question.

```
-------File Saldo Buku Tambahan-------
                +-------+
Akses File untuk Data Tahun ¦ 1992 ¦
                +-------+
```

```
                File Saldo Buku Tambahan
Tahun Periode  1992
Kode Perkiraan 133     Nama Piutang Jaminan Perusahaan (Kontraktor)
Kode B.T.      0001    Nama PT. Maju Jaya
```

	Saldo Awal	Mutasi Debit	Mutasi Kredit	Saldo Akhir
1	0.00	0.00	0.00	0.00
2	0.00	0.00	0.00	0.00
3	0.00	0.00	0.00	0.00
4	0.00	1,470,000.00	0.00	1,470,000.00
5	0.00	0.00	0.00	0.00
10	0.00	0.00	0.00	0.00
11	0.00	0.00	0.00	0.00
12	0.00	0.00	0.00	0.00

After the operator selects the appropriate year, the screen on the right appears. The screen depicts the balance of one of the accounts within the accounting system. In this instance it is with the contractor P.T. Maju Jaya.

The operator may want additional information concerning this account. The selection of the next set of screens reveals the detail associated with each document.

```
            File Saldo per Nomor Dokument
Tahun Periode  1992
Kode Perkiraan 133      Piutang Jaminan Perusahaan (Kontraktor)
Nomor Dokument 12345678
Kode B.T.     0001     PT. Maju Jaya
Tgl.Transaksi  10-08-19
Jatuh Tempo    30 Hari  Tgl.Jatuh Tempo 09-09-19
Keterangan     Ali Makmur
Penambahan          120,000.00
Pembayaran            0.00
Tgl.Pembayaran  - -
   Penambahan      Pembayaran
  Sum. Voucher    Sum. Voucher
  AR 1001   _          _    [ ] Informasi Saldo

  <Entri> <Hapus> «Simpan» <Batal> <Wewenang> <Cari>
```

Moving back up to the file menu and selecting the second option "Cetak Dafter" reveals the following menu.

This set of menus allows the operator to print a series of reports associated with the chart of accounts and the general ledger.

```
  RS Tegalyoso
  Menu Cetak Daftar
----------------------
1. Kode Perkiraan
2. Tipe Buku Tambahan
3. Kode Buku Tambahan
----------------------
Pilih dengan
Option:32
```

```
--Cetak Daftar Kode Perkiraan Buku
Besar-

 Kode Perkiraan          s/d
Total Level     s/d

     « Proses »   < Batal >
```

The selection of the chart of accounts option reveals: A screen that prompts the operator to list the range of codes that are to be printed and the levels of detail within each of the codes to be processed.

After the range of codes are provided, the system prompts the operator to specify where the output should be directed. The screen to the right appears. Selecting the output option box, the operator is provided a list of other output devices.

```
---------------Siapkan Printer------
        +-------------+
Cetak Ke ¦ SCREEN Temp ¦

Lebar Kertas (□) 8.5 Inch
          ( ) 14 Inch     <Batal
          ( ) Khusus
Printer:
[ ] Printer Server Setup...
```

Returning to the updating sub-menu, the operator may choose the "Tipe Buku" option. The following screen then appears. The operator selects the relevant range and then chooses the process button. A screen requesting the routing of output then appears as in the previous case.

```
--Cetak Daftar Tipe Buku Tambahan-

Tipe Buku Tambahan  s/d

  « Proses »  < Batal >
```

The last selection of the print menu prompts the operator for the name and type of book. As in the previous two requests the operator is then requested to provide the output destination for the processing results.

```
--Cetak Daftar Kode Buku Tambahan---

Tipe Buku Tambahan
Kode Buku Tambahan      s/d

  « Proses »  < Batal >
```

```
        RS Tegalyoso
     Menu Definisi Laporan
-----------------------------------
1. Laporan Neraca & Rugi/Laba
2. Laporan Perincian Buku Besar
3. Laporan Perincian Buku
4. Laporan Perincian No.Dokument
-----------------------------------
Pilih dengan
Option:33
```

Returning to the file entry and correction menu the selection of various options allows the user to change report definitions. The reports are associated with the files previously discussed and include the profit and loss statement, general ledger, various sub ledgers, and listing of the invoices that provide the basis for all transactions in the accounting system.

The selection of the general ledger option reveals the following screen.

```
        File Definisi Laporan Perincian Buku Besar
Nama Laporan     AR-01
Judul Menu       Daftar Piutang Pasien Jaminan Perusahaan
Judul Laporan  1 Daftar Piutang Pasien Jaminan Perusahaan
          2 Pertanggal: @P
          3
Rate Laporan        1.0000
Lebar Kertas     K (Kecil/Lebar)   Cetak No.Urut Y
Kode Buku Tamb.  Y Kode    Tipe C
Keterangan       Y Nama Perusahaan

          Print Header          Nilai Filter NB Total
Kolom 1        Y     Saldo Awal     B        +   Y
Kolom 2        Y       Mutasi       M        +   Y
Kolom 3        Y     Saldo Akhir    E   Z    +   Y

Kode Perkiraan 1 133     +

<Entri> <Hapus> «Simpan» <Batal> <Wewenang> <Cari> <Sblm>
```

The general ledger screen allows the operator to specify the account or range of accounts that are to be analyzed.

The selection of the more detailed version of the general ledger reveals a similar screen.

```
          File Definisi Laporan Perincian Buku Besar
Nama Laporan GL-01  Menu Perincian Saldo Kas dan Bank
Judul Lap. 1 Perincian Saldo Kas dan Bank
       2 Per: @P
       3
Rate Laporan    1.0000  Lebar Kertas K (Kecil/Lebar)
Nomor Urut  Y  Kode Perkiraan Y
Keterangan  Y Keterangan
                        Bln Nilai Filter Total NB
Jumlah    1 Y    Saldo Awal      0  B        Y  +
      2 Y     Mutasi        0  M        Y  +
      3 Y    Saldo Akhir     0  E        Y  +
      4 N     Budget        0  P        Y  +

         Dari    Hingga   NB Level   Dari    Hingga   NB Level
Kode Perkiraan 11      1299     +  3                    0
                        0                    0
                        0                    0
                        0                    0
                        0                    0

 <Entri> <Hapus> «Simpan» <Batal> <Wewenang> <Cari> <Sebelum> <Berikut>
```

The next menu allows the operator to modify the basic document report form. The operator may select various time periods to age the accounts as well as select ranges of account codes to analyze.

```
          File Definisi Laporan Perincian Nomor Dokument
Nama Laporan   AR-01  Menu Daftar Piutang Pasien Jaminan Perusahaan
Judul Laporan 1 Daftar Piutang Pasien Jaminan Perusahaan
          2 Pertanggal: @P
          3                          Rate    1.0000
Lebar Kertas   L (Kecil/Lebar)  Cetak Alamat N  Cetak Kode2 N  No.Urut Y
Kode Buku Tamb. Y Kode  Subtot.Y  No.Dokument  Y No.Register    Tgl.Dok Y
Tgl.Jatuh Tempo Y   Keterangan Y   Keterangan
Nilai Dokument  Y   J u m l a h        Analisa Pembayaran N
      Umur 1 Y   0 s/d  30   Umur 1 - 30
          2 Y   31 s/d  60   Umur 31 - 60
          3 Y   61 s/d  90   Umur 61 - 90
          4 Y   91 s/d 9999   Umur 90 - dst
          5 N    0 s/d   0
Pembayaran     Y   Pembayaran            Tgl.Bayar   Y
Saldo Transaksi Y    S a l d o   +-       Cetak Total  Y
Tanda Tangan   N                        Catatan Kaki N
Kode Buku Tamb.     s/d              Cetak per-periode E
Kode Perkiraan  133     s/d 133            s/d
                s/d                 s/d
                s/d                 s/d

  <Entri>  <Hapus>  «Simpan»  <Batal>  <Wewenang>  <Cari>  <Sebelum>
<Berikut>
```

```
RS Tegalyoso
Menu Laporan
-----------------------------------------
1. Menu Laporan Umum
2. Menu Laporan Keuangan
3. Menu Laporan Perincian Buku Besar
4. Menu Laporan Perincian Buku Tambahan
5. Menu Laporan Perincian Nomor Dokument
X. Lihat File Hasil Laporan.
-----------------------------------------
Pilih dengan
Option:4
```

The last major option from the main menu is associated with the writing of the reports required of the financial system. Selection of the the report option reveals the report menu.

The selection of the public report item then reveals a menu listing further report options.

```
RS Tegalyoso
Menu Laporan Umum
-----------------------------------
1. Daftar Kode Perkiraan Buku Besar
2. Summary Trial Balance
3. Detail Trial Balance (Buku Besar)
-----------------------------------
Pilih dengan
Option:41
```

The selection of any of the report options then prompts the operator to provide the time frame covered by the report and the destination of any output.

```
-----------------Laporan Keuangan----------------
---

1. [NE-01] Laporan Neraca
2. [RL-01] Laporan Perhitungan Rugi-Laba

-----------------------------------------------+
              < OK >
```

The selection of the financial report option from the report menu lists two different reports:

The reports are main financial states and the profit loss statement:

The selection of either report prompts the operator to input the relevant dates. The various account codes that make up the chart of accounts are based on the input from PQM.

```
-----------------Cetak Laporan Keuangan---------
--------
Nama Laporan    NE-01
Judul Laporan   Laporan Neraca
Periode Laporan 19-08-1992
Rate Laporan        1.0000

      « Cetak »       < Batal >
```

```
-----------Laporan Perincian Buku Besar-----
1. [GL-01] Perincian Saldo Kas dan Bank
2. [GL-02] Laporan Perincian Persediaan
```

The menu to the left allows the operator to select two reports from the general ledger.

Selection of either report provides the operator with a screen prompt for dates and another screen subsequently prompting for output destination.

The selection of the account receivable report menu reveals two reports. The selection of which provides the same set of options found in the previous menus.

```
--------Laporan Perincian Buku Tambahan---------
1. [AR-01] Daftar Piutang Pasien Jaminan Perusahaan
2. [AR-02] Daftar Piutang Karyawan
```

The selection of the next menu items again reveals the option for two more reports. The selection of either then prompts the operator for the usual input.

```
---------Laporan Perincian Nomor Dokument--------
1. [AR-01] Daftar Piutang Pasien Jaminan Perusahaan
2. [AR-02] Daftar Hutang Dagang
```

The final item in the report menu allows the operator to view the results of different screen saves that may have occurred during the session.

```
-------------------Tampilkan Hasil Laporan-------------------
|                                        |
|                                        |
| +-------------------------------------------------------+

| Group          Jml Halaman    0    Tanggal  - -  |
| Program          Pemakai            Jam  :  :  |
+-Keterangan ----------------------------------------|
|                                        _|
|                                        _|
|                                        _|
+----------------------------------------(      0)+
    « Koreksi » < Hapus > < Cari  > < Tamat >
```

During a session the operator has the option of outputting his or her work to the printer or to a computer file. The present options allow the operator to review his or her work prior to printing.

If the operator wants to correct or change a report format, he or she chooses the correction button at the bottom of the screen. This concludes the options that are available within the report options of the financial system.

```
                File Hasil Laporan
Judul
Nomor ID        Group        Jml Halaman    0
Program                Tanggal  - -
Pemakai                  Jam  :  :   Besar Lap. 0
+Keterangan ---------------------------------------------+
|                                                  _|
|                                                  _|
|                                                  _|
+-------------------------------------------------------+
«Entri» «Simpan» <Batal > <Laporan> <Sblm>
```

```
RS Tegalyoso
Menu Utilitas
---------------------------
1. Mengubah Kata Sandi
2. Lokasi File System
3. Lokasi File Akunting
4. Daftar Pemakai
Komputer
5. Indexing File
6. Packing File
7. Set Wewenang Khusus
8. Set System Variable
F. FoxPro Command
---------------------------
Pilih dengan
Option:U
```

The next set of screens are from the utility options from the main menu. The options are the same as those found in the quality assurance and management information system (QA/MIS).

As in the QA/MIS system there are options that allow the operator to change his or her password. The indexing and packing options are for daily system maintenance. There is an option that sets the various authorities to be used as part of the security system.

The location of the system files may be found by selecting the first option of the utilities menu.

As may be seen, the structure of the system files are similar to the QA/MIS system.

```
Lokasi File Sistem

FSMENU  File Definisi Menu              lib\
FSID    File Daftar Pemakai Komputer    lib\
FSOTOR  File Otorisasi                  lib\
FSHELP  File Penjelasan / Help          lib\
FSRDEF  File Definisi Report / Proses   prg'
FSMEMO  File Pesan / Memo               lib\
FSCRREP File Hasil Laporan              lib\
FSINFO  File Informasi Sistem           lib\

« Simpan »   < Batal >
```

This was expressly designed into the system to allow further integration with the financial system or any other system that may be developed in the future. In addition, the similarity in structure reduces the training requirements as the hospitals are introduced into the systems.

The location of the accounting files may be found or changed through the choice of this option.

```
Lokasi File Akunting
FGL0000  File Transaksi Harian          DATA\
FGLTT    File Transaksi Harian (Diskette) DATA\
FGLM     File Kode Perkiraan Buku Besar  DATA\
FGLD     File Saldo Perkiraan Buku Besar DATA\
FTCS     File Tabel Kode Buku Tambahan   DATA\
FCS      File Kode Buku Tambahan         DATA\
FGLCS00  File Saldo Buku Tambahan        DATA\
FGLS00   File Perincian Nomor Dokument   DATA\
-------------------------------------------
FRSTH    File Header Def. Lap. Keuangan  LIB\
FRSTD    File Detail Def. Lap. Keuangan  LIB\
FRSCGL   File Def. Lap. Schedule G/L     LIB\
FRGLCS   File Def. Lap. Buku Tambahan    LIB\
```

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SECTION ONE

HOSPITAL BILLING SYSTEM

Quality Assurance [DIREKTUR] 27-07-1992 10:10:45

Registrasi Pasien Rawat Nginap

No. Reg.	00000001		
No. CM.	000003	Dirawat Ke	1
Nama Pasien			Sex
Tgl. Lahir		Alamat	
Prosedur Masuk RS	2		
Dikirim Oleh	1		Kasus Polisi (Y/T) T
Bagian/UPF	09		
Bangsal	01		Kelas IIIA
Tgl. Masuk	01-01-1992	Jam 23:30	Umur Saat Masuk
Tgl. Keluar	10-01-1992	Jam 10:10	Lama Dirawat Hari
Sebab Dirawat	Jatuh dari pohon		
Dr. Jaga (NIP/NRP)	NIP. 12		
Keadaan Keluar	2		
Cara Keluar	1		
Dokter (NIP/NRP)	NIP. 123		
Cara Pembayaran	1		
Jaminan Kantor			

[X] Diagnosa & Tindakan
[X] Data Pasien

«Simpan» <Batal> <Cari> <Sblm> <Brkt> <Hapus> <Wewenang>

Lo

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Quality Assurance [DIREKTUR] 27-07-1992 10:10:45

Registrasi Pasien Rawat Nginap

Diagnosa & Tindakan

Diagnosa Utama 1	187.5
Diagnosa Utama 2	
Komplikasi 1	462
Komplikasi 2	
Penyakit Lain 1	401
Penyakit Lain 2	
Penyebab Luar Cedera	E925
Tindakan 1	5-010
Tindakan 2	
Infeksi Nosokomial	01
Penyebab IN	1
Transfusi Darah	2,500 cc
Radioterapi	1

Catatan Catatan/Resume diisi di sini

(Tab/Shift+Tab - Keluar)

« OK »

Lo

Data Pasien Rawat Nginap

No. CM. 000003
Nama Pasien Abdul Hasan Sex (L/P) L
Alamat Jl. Manggis No. 89
Kelurahan Cendana RT/RW 003/003
Kecamatan Kebon Kacang Kabupaten/Kodya Delima
No. KTP/SIM 123.456.789.012.3456 No. Telepon (0123)-1234567
Suku Bangsa 3 Agama 1
Tgl. Lahir 03-03-1952 Umur Status Kawin 3
Pendidikan 3
Pekerjaan Karyawan H.I. (Y/T) T
KELUARGA TERDEKAT: [X] Immunisasi

1. Nama Mohammad No. Telp
   Alamat Jl. Kelapa No. 55 (021)-311234

2. Nama Umar Umur 60 (•) Ayah
   Pekerjaan Petani ( ) Suami

3. Nama Siti Mariam Umur 50 (•) Ibu
   Pekerjaan Ibu Rumah Tangga ( ) Isteri

«Simpan» <Batal>

Lo

DEPKES INDONESIA

Date: 28-07-1992
Page: 1
Prog: RRRCHBY

PASIEN RENCANA PULANG

No. Reg / No. CM : 00000001 / 000003
Nama Pasien : Abdul Hasan
Dirawat Diruang : Anggrek Kelas: VIP

Tanggal	Kode Pelayanan	Uraian	Qty	Bahan	Jasa RS	Jasa Med.	Total	No. Tagih	Tgl Tagih
01-07-1992	02.01	Akomodasi Kelas IIIA	1.00	0	2,500	0	2,500	00000001	27-07-1992
02-07-1992	02.01	Akomodasi Kelas IIIA	10.00	0	25,000	0	25,000	00000001	27-07-1992
03-07-1992	04.02.1.01.01.1	L E D - Kls III	2.00	600	300	200	1,100	00000001	27-07-1992
04-07-1992	04.02.1.01.02.1	Hematokrit - Kls III	5.00	1,500	750	500	2,750	00000001	27-07-1992
05-07-1992	04.02.1.01.01.1	L E D - Kls III	1.00	300	150	100	550	00000001	27-07-1992
10-07-1992	05.02.2.01.02.1	Histopathologi - Kelenjar Getah Bening	1.00	6,000	3,000	3,000	12,000	00000001	27-07-1992
12-07-1992	06.01.1.01.01.1	Photo Gigi Biasa	1.00	2,000	1,000	600	3,600	00000001	27-07-1992
16-07-1992	02.01	Akomodasi Kelas IIIA	2.00	0	5,000	0	5,000	00000002	27-07-1992
17-07-1992	03.01	Kelas IIIA	2.00	0	3,000	0	3,000	00000002	27-07-1992
20-07-1992	02.01	Akomodasi Kelas IIIA	1.00	0	2,500	0	2,500	00000010	27-07-1992
20-07-1992	07.01.1.01.01.1	E.C.G	1.00	1,500	1,500	1,500	4,500	00000010	27-07-1992
24-07-1992	16.01	Fasilitas Jenazah	1.00	2,000	1,000	1,000	4,000	00000011	27-07-1992
			28.00	13,900	45,700	6,900	66,500		

RSU TEGALYOSO
Telepon (0272)-21104
Jl. Dr. Soeradji Klaten

NO. 00000001

Tanggal: 27-07-1992

BIAYA RAWAT NGINAP

NO. REG / NO. MR : 00000001 / 000003
NAMA PASIEN : Abdul Hasan
DIRAWAT DI RUANG : Anggrek KELAS : VIP
TANGGAL : 1 Juli 1992 s/d 12 Juli 1992
CARA PEMBAYARAN : 1 (TUNAI)

URAIAN	QTY	BAHAN	JASA RS	JASA MED.	TOTAL
02. Tarip Rawat Nginap	11.00	0	27,500	0	27,500
04. Tarip Pemeriksaan Laboratorium Klinik	8.00	2,400	1,200	800	4,400
05. Tarip Pemeriksaan Laboratorium Patologi Anatomi	1.00	6,000	3,000	3,000	12,000
06. Tarip Pemeriksaan Radio Diagnostik	1.00	2,000	1,000	600	3,600
J U M L A H		10,400	32,700	4,400	47,500

Terbilang : Empat Puluh Tujuh Ribu Lima Ratus Rupiah.

Keterangan :
Tgl. Operasi : 1.
2.

Catatan :

Jakarta, 28 Juli 1992
Tata Usaha Rawat

Nama Jelas

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PERINCIAN BIAYA RAWAT NGINAP

No. Tagihan : 00000001
Tanggal Tagihan : 27 Juli 1992
No. Reg / No. CM : 00000001 / 000003 Nama Pasien : Abdul Hasan
Dirawat Diruang : Anggrek Kelas : VIP
Tanggal : 1 Juli 1992 s/d 12 Juli 1992

Kode Pelayanan	Uraian	Tanggal	Qty	Bahan	Jasa RS	Jasa Med.	Total
02.	Tarip Rawat Nginap						
02.01	Akomodasi Kelas IIIA	01-07-1992	1.00	0	2,500	0	2,500
02.01	Akomodasi Kelas IIIA	02-07-1992	10.00	0	25,000	0	25,000
		* Sub Total	11.00	0	27,500	0	27,500
04.	Tarip Pemeriksaan Laboratorium Klinik						
04.02.1.01.01.1	L E D - Kls III	03-07-1992	2.00	600	300	200	1,100
04.02.1.01.01.1	L E D - Kls III	05-07-1992	1.00	300	150	100	550
04.02.1.01.02.1	Hematokrit - Kls III	04-07-1992	5.00	1,500	750	500	2,750
		* Sub Total	8.00	2,400	1,200	800	4,400
05.	Tarip Pemeriksaan Laboratorium Patologi Anatomi						
05.02.2.01.02.1	Histopathologi - Kelenjar Getah Bening	10-07-1992	1.00	6,000	3,000	3,000	12,000
		* Sub Total	1.00	6,000	3,000	3,000	12,000
06.	Tarip Pemeriksaan Radio Diagnostik						
06.01.1.01.01.1	Photo Gigi Biasa	12-07-1992	1.00	2,000	1,000	600	3,600
		* Sub Total	1.00	2,000	1,000	600	3,600
		** T O T A L		10,400	32,700	4,400	47,500

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DEPKES INDONESIA

REGISTER PENDAFTARAN PASIEN RAWAT NGINAP (REG3)

Date: 28-07-1992
Page: 1
Prog: RRREG03

Tgl / Bulan	NOMOR No. Urut	NOMOR Dokumen Medik	Nama Lengkap	Alamat Lengkap	Umur	JNS KEL Laki-laki	JNS KEL Lipilalu	Pekerjaan Pasien	CARA PENERIMAAN PASIEN Merujuk	CARA PENERIMAAN PASIEN Datang Sendiri	ASAL PASIEN RUJUKAN Puskesmas	ASAL PASIEN RUJUKAN RS Lain	ASAL PASIEN RUJUKAN Dokter	ASAL PASIEN RUJUKAN Kasus Polisi	ASAL PASIEN RUJUKAN Lain-Lain	Nama Ruang Rawat	Kelas Perawatan	KELUAR RS Tanggal	KELUAR RS Jam	CARA PASIEN KELUAR Perset ujuan	CARA PASIEN KELUAR Pulang Paksa	CARA PASIEN KELUAR Pindah RS Lain	CARA PASIEN KELUAR Meninggal	CARA PASIEN KELUAR Lain-Lain	PASIEN KELUAR MATI < 48 Jam	PASIEN KELUAR MATI > 48 Jam	CARA PEMBAYARAN Bayar Pemuh	CARA PEMBAYARAN PMB / DU KM / AS TEK / Kantor	CARA PEMBAYARAN Nat pl dana	CARA PEMBAYARAN Tidak / Kurang	CARA PEMBAYARAN Lain-Lain Mampu
01/01	000000001	000003	Abdul Hasan	Jl. Manggis No. 89	39 TH	L	Karyawan						X			Anggrek	VIP	- -	:	X												
02/02	000000002	000002	Sylvester Stalong	Jl. Ring Baja 15	30 TH	L	Pelawak		X					X		Anggrek	VIP	- -	:		X											
01/07	000000003	000006	Helen Killer	Jl. Sekitar Benhil	32 TH	P	Karyawan					X				Melati	II	- -	:								X		X			
03/07	000000005	000003	Abdul Hasan	Jl. Manggis No. 89	40 TH	L	Karyawan	X							X	Melati	II	09-07-1992	12:59			X										
12/06	000000006	003010	Pity	Jl. Melinjo	61 TH	L	Tukang buah	X						X		Melati	VIP	17-06-1992	09:10		X										X	
03/07	000000007	000001	Ken Pedes	Jl. Gajahpahit	60 TH	P	Wiraswasta		X	X						Mawar	IIIA	09-07-1992	23:00	X									X			
10/07	000000008	000010	Pity	Jl. Melinjo	61 TH	L	Tukang buah							X		Melati	VIP	14-07-1992	12:00										X			
23/11	000000011	000010	Pity	Jl. Melinjo	60 TH	L	Tukang buah		X					X		Melati	II	- -	:										X			
14/07	000000013	000008	Kiky Fatmalala	Jl. Matraman Dalam III / 12 Jakarta	23 TH	P		X						X		Anggrek	II	- -	:													
15/07	000000014	000010	Pity	Jl. Melinjo	61 TH	L	Tukang buah		X	X						Dahlia	IIIA	- -	:												X	
16/07	000000015	000003	Abdul Hasan	Jl. Manggis No. 89	40 TH	L	Karyawan						X			Dahlia	IIIA	- -	:										X			
18/07	000000016	000003	Abdul Hasan	Jl. Manggis No. 89	40 TH	L	Karyawan			X			X			Dahlia	IIIA	19-07-1992	10:00	X									X			
15/07	000000017	000002	Sylvester Stalong	Jl. Ring Baja 15	30 TH	P	Pelawak			X	X					Anggrek	II	- -	:										X			
20/07	000000018	000004	Pailul	Jl. Gajahpahit No. 999	30 TH	L	Satpam		X		X		X			Cendrawasih	VIP	- -	:	X									X			
22/07	000000024	00000006	Angelina	Komplek Sandang KH. Syahdan	20 TH	P	Mahasiswa		X				X			Melati	VIP	- -	:													
28/07	000000025	00000006	Angelina	Komplek Sandang KH. Syahdan	20 TH	P	Mahasiswa		X				X			Anggrek	VIP	- -	:													
1"8/07	000000026	000010	Pity	Jl. Melinjo	61 TH	L	Tukang buah	X			X					Dahlia	IIIA	- -	:													
28/07	000000027	000002	Sylvester Stalong	Jl. Ring Baja 15	30 TH	L	Pelawak		X				X			Mawar	IIIA	- -	:													

DEPKES INDONESIA

Date: 28-07-1992
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Prog: RRHED04

JENIS PELAYANAN : 01 - Penyakit Dalam

BUKU REGISTER PELAYANAN PASIEN RAWAT NGINAP (REG4)

Tanggal/ Bulan	Jam	NOMOR Urut	NOMOR Dokumen Medik	Nama Pasien	Alamat	UMUR/ JENIS KELAMIN Laki-laki	UMUR/ JENIS KELAMIN Perempuan	Kelas Perawatan	Diagnosis Utama	Komplikasi	Diagnosis Lain	Penyebab Luar Kecelakaan	Nama Dokter yang Merawat	CARA PEMBAYARAN Tunai	CARA PEMBAYARAN Sel PMB	CARA PEMBAYARAN Jaminan Kantor	CARA PEMBAYARAN Ang Sur an	CARA PEMBAYARAN Fasilitas / SK TM	CARA PEMBAYARAN M/K	CARA PEMBAYARAN Lain - lain	Jumlah Perincian Biaya	Jumlah yang Dibayar	Keterangan
01 / 07	10:10	00000003	000006	Helen Killer	Jl. Sekitar		1	32 TH	II	250.0					X						0	0	

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DEPKES INDONESIA

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JENIS PELAYANAN : 02 - Bedah

BUKU REGISTER PELAYANAN PASIEN RAWAT NGINAP (REG4)

Tanggal/ Bulan	Jam	NOMOR Urut	NOMOR Dokumen Medik	Nama Pasien	Alamat	UMUR/ JENIS KELAMIN Laki-laki	UMUR/ JENIS KELAMIN Perempuan	Kelas Perawatan	Diagnosis Utama	Komplikasi	Diagnosis Lain	Penyebab Luar Kecelakaan	Nama Dokter yang Merawat	CARA PEMBAYARAN Tunai	CARA PEMBAYARAN Sel.PHB	CARA PEMBAYARAN Jaminan Kantor	CARA PEMBAYARAN Angs.Surat	CARA PEMBAYARAN Fasilitas/SKTM	CARA PEMBAYARAN K/K	CARA PEMBAYARAN Lain-lain	Jumlah Perincian Biaya	Jumlah yang Dibayar	Keterangan
01 / 01	23:30	00000001	000003	Abdul Hasan	Jl. Manggis	39 TH		VIP	187.5	462	481	E925		X							66,500	66,500	Catatan/Resume diisi di sini
02 / 02	14:00	00000002	000002	Sylvester Stalong	Jl. Ring Baja	30 TH		VIP	301												92,800	92,800	
14 / 07	12:10	00000013	000008	Kiky Fatmalala	Jl. Matraman		23 TH	II								X					0	0	
15 / 07	20:20	00000017	000002	Sylvester Stalong	Jl. Ring Baja	30 TH		II									X				0	0	
28 / 07	10:10	00000025	00000006	Angelina	Komplek		20 TH	VIP													0	0	

DEPKES INDONESIA

Date: 28-07-1992
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Prog: RRSENSUS

SENSUS HARIAN PASIEN RAWAT NGINAP (RP1a)

Hari: Selasa Tgl: 28-07-1992
sampai jam 24.00

UPF : Bedah
Ruang: Anggrek Kelas: VIP
Jumlah Penderita Awal: 2 orang.

No. Reg.	No. CM	Nama Penderita	PENDERITA MASUK: DARI POLIKLINIK ATAU U G D: Datang Sendiri	Rujukan	PINDAHAN ANTAR RUANGAN: Pindah Dari Ruangan	Kelas	DIPINDAH: Pindah Ke Ruangan	Kelas	PENDERITA KELUAR: KELUAR: Tanggal Masuk	Cara Keluar: Perse tujuan	Pulang Paksa	Pindah RS	Meninggal	Lain-lain	Meninggal: < 48 jam	> 48 jam
00000025	00000006	Angelina		X												

Sisa: 2 orang.

Kepala Ruang:

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DEPKES INDONESIA

Date: 29-07-1992
Page: 1
Prog: RRSENS2

SENSUS HARIAN PASIEN RAWAT NGINAP

HARI: Rabu TANGGAL: 29 Juli 1992
SAMPAI JAM 24.00

RUANG RAWAT NGINAP: Anggrek
TT TERSEDIA : 4

KLS UTAMA	2	TT
KLS I	2	TT
KLS II	0	TT
KLS IIIA	0	TT
KLS IIIB	0	TT

NAMA RUMAH SAKIT: RSU Tegalyoso

No	Nama Pasien	No D.M	Kelas	PASIEN MASUK RUANG RAWAT NGINAP: PASIEN MASUK: Datang Sendiri	PASIEN MASUK: Rujukan	PASIEN PINDAH DARI RUANG LAIN: Ruang	PASIEN PINDAH DARI RUANG LAIN: Kelas	PASIEN DIPINDAHKAN KE RUANG LAIN: Ruang	PASIEN DIPINDAHKAN KE RUANG LAIN: Kelas	PASIEN KELUAR RUANGAN: Tanggal Masuk RS	KELUAR RUMAH SAKIT: CARA PASIEN KELUAR: Diizinkan Pulang	Dirujuk ke RS Lebih Tinggi	Dirujuk ke RS Lebih Rendah	Dirujuk ke Puskesmas	Dirujuk ke Panti	Pindah ke RS Lain	Pulang Paksa	Lari	Lain-lain	MENINGGAL: Kurang dari 48 jam	Lebih dari 48 jam
1	Angelina	00000006	VIP		X																

RESUME

	KL.UT	KL.I	KL.II	KL.III	JUMLAH
1. PASIEN AWAL	3	1	1		5
2. PASIEN MASUK	1				1
3. PASIEN PINDAHAN					
4. TOTAL PASIEN DIRAWAT(1+2+3)	4	1	1		6
5. PASIEN DIIJINKAN PULANG					
6. PASIEN DIRUJUK					
7. PASIEN PINDAH KE RS LAIN					
8. PASIEN PULANG PAKSA					
9. PASIEN MELARIKAN DIRI					
10. TOTAL PASIEN KELUAR HIDUP (5+6+7+8+9)					

	KL.UT	KL.I	KL.II	KL.III	JUMLAH
11. PASIEN DIPINDAHKAN					
12. MATI KURANG 48 JAM					
13. MATI SELAMA 48 JAM & LEBIH					
14. TOTAL PASIEN KELUAR (10+11+12+13)					
15. BANYAKNYA PASIEN YANG MASIH DIRAWAT (4-14)	4	1	1		6
16. PASIEN MASUK DAN KELUAR PADA HARI YANG SAMA					

DIBUAT PADA TGL: 29 Juli 1992
KEPALA RUANG RAWAT NGINAP

(.....)

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DEPKES INDONESIA

Date: 29-07-1992
Page: 1
Prog: RRSENSKP

REKAPITULASI SENSUS HARIAN PASIEN RAWAT NGINAP (RP2)

Hari : Rabu Tanggal : 29 Juli 1992
Sampai jam 24.00

Nama Rumah Sakit : RSU Tegalyoso

No	Ruang Rawat Nginap	Pasien Awal	Pasien Masuk	Pasien Pindahan	Pasien Dipindahkan	Pasien Keluar Hidup	Pasien Mati	PERINCIAN PASIEN MATI < 48 Jam	PERINCIAN PASIEN MATI > 48 Jam	Jumlah Lama Dirawat	Pasien Sisa (yg masih dirawat)	PERINCIAN PASIEN SISA Kelas Utama VIP	Kelas I	Kelas II	Kelas IIIA	Kelas IIIB	Pasien Keluar/Masuk Pada hari yang sama	Keterangan
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1	Mawar	1	1								2				2			
2	Anggrek	5	1								6	4	1	1				
3	Dahlia	3	1								4				4			
	TOTAL	9	3								12	4	1	1	6			

29 Juli 1992
Kepala Unit Pencatatan Medik

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DEPKES INDONESIA

No. Kode Rumah Sakit : 3310015
Nama Rumah Sakit : RSU Tegalyoso

DATA KEGIATAN RUMAH SAKIT (RL1)

Triwulan : III 1992

Date: 28-07-1992
Page: 1
Prog: RRDTKG

1. PELAYANAN RAWAT NGINAP

No	Jenis Pelayanan/ Ruang Rawat Nginap	Pasien awal triwulan	Pasien masuk	Pasien keluar hidup	Pasien keluar mati	Perincian pasien keluar mati		Jumlah lama dirawat	Pasien akhir triwulan	Jumlah hari perawatan	Perincian hari perawatan per kelas					Maksimum Sensus Harian	Keterangan
						< 48 jam	> 48 jam				Kelas utama	Kelas I	Kelas II	Kelas IIIA	Kelas IIIB		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		
01	Penyakit Dalam		1						1			1					
02	Bedah		3						3		1	1	1				
03	Kesehatan Anak		6	2				9	4	9				6			
04	Obstetri		1					5		5	1						
05	Ginekologi																
06	Bedah Saraf																
07	Saraf																
08	Jiwa																
09	T.H.T																
10	Mata																
11	Kulit dan Kelamin																
12	Gigi dan Mulut																
13	Kardiologi																
14	Radioterapi/Kedokteran Nuklir																
15	Bedah Orthopedi																
16	Paru-paru																
17	Kusta																
18	Umum		3	1				7	2	7	2	1					
19	Unit Darurat																
20	Rehabilitasi Medis																
21	Isolasi																
22	Luka Bakar																
23	I.C.U																
24	I.C.C.U																
88	Perinatologi/Bayi																
99	T O T A L		14	3				21	10	21	4	3	1	6			

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DEPKES INDONESIA

Date: 28-07-1992
Page: 1
Prog: RRRL2A

DATA KEADAAN MORBIDITAS PASIEN RAWAT NGINAP RUMAH SAKIT (RL2A)

Bulan/Tahun : Juli/1992

Nama Rumah Sakit : RSU Tegalyoso Alamat : Jl. Dr. Soeradji Klaten No. Kode RS : 3310015

No Urut	Nomor Daftar Terperinci	Golongan Sebab-sebab Sakit	Pasien Keluar Hidup dan Mati Menurut Golongan Umur (Tahun)							Pasien Keluar Hidup & Mati Menurut Seks		Jumlah Pasien Keluar	Jumlah Pasien Keluar Mati
			< 1	1 - 4	5 - 14	15-24	25-44	45-64	>=65	Laki-laki	Perempuan		
1	2	3	4	5	6	7	8	9	10	11	12	13	14
1	002	Typhoid And Paratyphoid Fever											
2	005.9	Food Poisoing											
3	009.0	Dysentery											
4	009.1	Colitis, Enteritis, Gastroenteritis						1			1	1	
5	009.3	Diarhea/ Enteretis											
6	011	Pulmonary Tuberculosis (KP)											
7	011.9	Hemoptysis - KP						1		1		1	
8	011.9	Tuberculosis Pulmonary											
9	017	Lymphadenitis (TBC Kelenjar)											
10	033.9	Pertussis											
11	035	Erysipelas											
12	038.9	Septicemia											
13	052	Varicella											
14	053.9	Herpes Zoster											
15	055.9	Morbilli											
16	056.9	German Measles											
17	056.9	Rubella											
18	057.8	Other Viral Exanthemata											
19	061	Dengue											
20	065	Arthropod Borne Haemorragic Fever					1			1		1	
21	065.4	Dengue Haemorrhagic Fever (DHF)											
22	070.1	Hepatitis Type A											
23	070.3	Hepatitis B											
24	079.9	Viral Infeksi											
25	079.9	Infeksi Viral											
26	079.9	Virus Infeksi											
27	084.0	Malaria Falci Farum											
28	084.6	Malaria											
29	091.3	Condyloma											
30	111.0	Pityriasis Versicolor											
31	112.0	Candidiasis Of Mouth											
32	117.9	Mycosis											
33	174.9	Cancer Mamae											
34	180.9	Neoplasm Cervix Uteri (Malignant)											
35	187.5	Malignant Neoplasim Of Epididymis											
36	208.9	Leukemia											
37	217	Fibroadenoma Mamae											
38	218	Myoma Uteri											
39	228.0	Hemangioma Cavernosum											
40	229.8	Benign Neoplasm Other Specifiedsites											
41	238.4	Polycythemia											
42		JUMLAH PER HALAMAN					1	2		2	1	3	

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DEPKES INDONESIA

DATA INVENTARISASI RUMAH SAKIT (RL 3)
Keadaan 31 Desember 1992

Date:28-07-1992
Page: 1
Prog: RRDTRS

1. Nomor Kode RS : 3310015
2. Nama RS : RSU Tegalyoso
3. Jenis RS : A RS Umum
4. Kelas RS : C
5. Nama Direktur RS : Dr. Sulaeman
6. Alamat/Lokasi RS : Jl. Dr. Soeradji Klaten
   Telepon : (0272)-21104
7. Kegiatan Dimulai : 1 Januari 1970
8. Surat Ijin / Penetapan:
   a. Nomor : 123/Yan.Kes/RS/70
   b. Tanggal : 31 Desember 1969
   c. Oleh : Menkes RI
   d. Sifat : Tetap
9. Penyelenggara RS:
   a. Nama : Departemen Kesehatan RI
   b. Status : 10 Departemen Kesehatan
10. Fasilitas Kesehatan Gigi:
   a. Kursi Gigi: 2
   b. Unit Gigi : 2

11. Fasilitas Tempat Tidur Menurut Rawat Nginap.

No	Jenis Pelayanan / Ruang Rawat Nginap	Alokasi Tempat Tidur	Perincian Tempat Tidur/Kelas					Luas Ruangan (M2)
			Kelas VIP	Kelas I	Kelas II	Kelas III	Kelas IV	
01	Penyakit Dalam	66	6	10	10	20	20	0
02	Bedah	0	0	0	0	0	0	0
03	Kesehatan Anak	0	0	0	0	0	0	0
04	Obstetri	0	0	0	0	0	0	0
05	Ginekologi	0	0	0	0	0	0	0
06	Bedah Saraf	0	0	0	0	0	0	0
07	Saraf	0	0	0	0	0	0	0
08	Jiwa	0	0	0	0	0	0	0
09	T.H.T	0	0	0	0	0	0	0
10	Mata	32	2	4	6	10	10	0
11	Kulit dan Kelamin	88	3	5	10	30	40	0
12	Gigi dan Mulut	0	0	0	0	0	0	0
13	Kardiologi	50	5	5	10	15	15	2000
14	Radioterapi/Kedokteran Nuklir	15	1	1	3	5	5	500
15	Bedah Orthopedi	0	0	0	0	0	0	0
16	Paru-paru	0	0	0	0	0	0	0
17	Kusta	0	0	0	0	0	0	0
18	Umum	90	10	5	15	30	30	500
19	Unit Darurat	0	0	0	0	0	0	0
20	Rehabilitasi Medis	0	0	0	0	0	0	0
21	Isolasi	0	0	0	0	0	0	0
22	Luka Bakar	0	0	0	0	0	0	0
23	I.C.U	0	0	0	0	0	0	0
24	I.C.C.U	0	0	0	0	0	0	0
38	Perinatologi/Bayi	0	0	0	0	0	0	0
99	T O T A L	341	27	30	54	110	120	3000

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DATA INVENTARISASI RUMAH SAKIT (RL 3)
Keadaan 31 Desember 1992

No. Kode RS: 3310015

12. Fasilitas Unit Rawat Jalan (Klinik).

Kode	Keterangan	Hari buka / Seminggu	Total buka / Seminggu
01.	Penyakit Dalam		7
A.	Alergi/Immunologi	4	
B.	Endokrin	3	
C.	Gastro entrologi	0	
D.	Hepatologi	0	
E.	Netrologi	0	
F.	Psikomatik	0	
G.	Reumatologi	0	
H.	Hematologi	0	
I.	Pulmonologi	0	
J.	Kardiologi	0	
02.	Bedah		17
A.	Orthopedi	0	
B.	Urologi	0	
C.	Kepala, leher, payudara	0	
D.	Plastik	0	
E.	Jantung	5	
F.	Anak	6	
G.	Vaskuler	2	
H.	Digestif	2	
I.	Tumor	2	
03.	Kesehatan Anak		8
A.	Alergi/Immunologi	1	
B.	Endokrinologi	0	
C.	Gastro entrologi	2	
D.	Hematologi	0	
E.	THT	0	
F.	Kardiologi	0	
G.	Nefrologi	0	
H.	Neurologi	0	
I.	Perinatologi	0	
J.	Pulmonologi	0	
K.	Radiologi	2	
L.	Gizi	3	
M.	Akupungtur	0	
N.	Penyakit tropis	0	
O.	ICU	0	
04.	Obstetri & Ginekologi		14
A.	Endokrinologi	0	
B.	Kesehatan Reproduksi	2	
C.	Onkologi	4	
D.	Perinatologi	2	
E.	Patologi/Sitologi	1	
F.	Urologi Wanita	5	
05.	Keluarga Berencana		3
06.	Bedah Syaraf		10

DATA INVENTARISASI RUMAH SAKIT (RL 3)
Keadaan 31 Desember 1992

No. Kode RS: 3310015

12. Fasilitas Unit Ra. . Jalan (Klinik).

Kode	Keterangan	Hari buka / Seminggu	Total buka / Seminggu
A.	Pediatrik	2	
B.	Vaskuler	2	
C.	Trauma	2	
D.	Saraf Perifer	1	
E.	Tumor	3	
07.	Saraf		12
A.	Nyeri Kepala	1	
B.	C V D	1	
C.	Epilepsi	1	
D.	Neuro Oftalmologi	2	
E.	Echo Ensafalografi	2	
F.	Trauma Kapitis	1	
G.	E M G	1	
H.	E E G	2	
I.	Neuro Psikologi	1	
08.	Jiwa		6
A.	Anak dan Remaja	2	
B.	Dewasa	2	
C.	Narkotika dan Alkohol	2	
09.	THT		9
A.	Neuro Otologi	1	
B.	Rhinologi	1	
C.	Onkologi	1	
D.	Otologi	2	
E.	Bronko Esofagologi	1	
F.	Laringo Faringologi	1	
G.	Bedah Plastik/Rekonstruksi	2	
10.	Mata		15
A.	Glaukoma	1	
B.	Kornea	2	
C.	Refraksi	2	
D.	Strabismus	1	
E.	Neuro Oftalmologi	1	
F.	Retina	1	
G.	Tumor	2	
H.	Penyakit Segmen Anterior	1	
I.	Mata Anak	2	
J.	Trauma/Bedah Plastik	2	
11.	Kulit & Kelamin		12
A.	Jamur	3	
B.	Sexually Transmited/Disease	1	
C.	Alergi Immunologi Kulit	1	
D.	Kosmetik Medik/Bedah Kulit	3	
E.	Kusta	1	
F.	Kulit Anak	2	
G.	Tumor Kulit	1	

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DATA INVENTARISASI RUMAH SAKIT (RL 3)
Keadaan 31 Desember 1992

No. Kode RS: 3310015

12. Fasilitas Unit Rawat Jalan (Klinik).

Kode	Keterangan	Hari buka / Seminggu	Total buka / Seminggu
12.	Gigi & Mulut		8
A.	Kompersasi Gigi	2	
B.	Periodentologi	1	
C.	Bedah Mulut	2	
D.	Paramedicine	1	
E.	Prastodentia	1	
F.	Ilmu Pedodontia	1	
13.	Kardiologi		12
A.	Jantung Bawaan	2	
B.	Jantung Rematik	1	
C.	Jantung Coroner	2	
D.	Jantung Hipertensil	2	
E.	Jantung Tropist/Miopatny	1	
F.	Bedah Jantung	1	
G.	Rehabilitasi	1	
H.	Laboratorium Non Invarsive	1	
I.	Laboratorium Invarsive	1	
14.	Radiologi		4
A.	Radio diagnostik	1	
B.	Radio Therapi	1	
C.	Kedokteran Nuklir	2	
15.	Bedah Orthopedi		2
16.	Paru-Paru		8
A.	Infeksi	2	
B.	Onkologi	1	
C.	Asma	2	
D.	Paru Kerja	1	
E.	Darurat Gawat Paru	2	
17.	Kusta		2
18.	Umum		2
A.	N P K	1	
B.	Pejabat Teras	1	
19.	Unit Darurat		3
A.	Bedah	1	
B.	Non Bedah	2	
20.	Rehabilitasi Medik		3
21.	Akupuntur Medik		0
22.	Gizi		1

Direktur Rumah Sakit:

Tanda tangan

Nama Terang

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DEPKES INDONESIA

Date: 28-07-1992
Page: 1
Prog. HRDTKT

DATA KEADAAN KETENAGAAN RUMAH SAKIT (RL4)

Nama Rumah Sakit : RSU Tegalyoso

No. Kode Rumah Sakit : 3310015

1. TENAGA MEDIK

Kode Ketenagaan	Kualifikasi Pendidikan	Status Kepegawaian: DepKes Dipekerjakan (Gaji Setjen)	DepKes Dipekerjakan (Gaji Yanmed)	DepKes Dipekerjakan (Gaji Kanril)	PNS DepKes (RS Vertikal)	PNS DepKes Dipebantukan	PNS Daerah (TK.I & TK.II)	PNS Depdikbud	ABRI termasuk PNS	PNS dep. Lain termasuk BUMN	Non Pegawai Negeri (Swasta)	Tenaga Part time *): PNS Depkes	PNS Daerah (TK.I & TK.II)	PNS Depdikbud	ABRI/PNS	PNS dep. Lain	Sub Total	Honorer (belum ada pengangkatan)	Total
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1.00	Dokter Umum																		
1.01	Dokter Asisten Ahli	1	1																
1.02	Dokter Ahli Bedah																		
1.03	Dokter Ahli Penyakit Dalam																		
1.04	Dokter Ahli Anak		1																
1.05	Dokter Ahli Obgin																		
1.06	Dokter Ahli Radiologi					1													
1.07	Dokter Ahli Anesthesia																	1	1
1.08	Dokter Ahli Patologi Klinik																		
1.09	Dokter Ahli Jiwa																		
1.10	Dokter Ahli Mata											1							
1.11	Dokter Ahli THT																		
1.12	Dokter Ahli Kulit & Kelamin																		
1.13	Dokter Ahli Kardiologi																		
1.14	Dokter Ahli Paru																		
1.15	Dokter Ahli Saraf																		
1.16	Dokter Ahli Bedah Saraf																		
1.17	Dokter Ahli Bedah Orthopedi																		
1.18	Dokter Ahli Urologi																		
1.19	Dokter Ahli Patologi Anatomi																		

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DEPKES INDONESIA

Date: 28-07-1992
Page: 1
Prog: RRDTKD

DATA KEADAAN KETENAGAAN RUMAH SAKIT (RL4)

Nama Rumah Sakit : RSU Tegalyoso
PERINCIAN DOKTER PASCA SARJANA MENURUT SPESIALISASI DAN INSTANSI INDUK

No. Kode Rumah Sakit : 3310015

No. Urut	Instansi Induk	Dokter Ahli Bedah	Dokter Ahli Penyakit Dalam	Dokter Ahli Anak	Dokter Ahli Obgin	Dokter Ahli Radiologi	Dokter Ahli Anesthesi	Dokter Ahli Patologi Klinik	Dokter Ahli Jiwa	Dokter Ahli Mata	Dokter Ahli THT	Dokter Ahli Kulit & Kelamin	Dokter Ahli Kardiologi	Dokter Ahli Paru	Dokter Ahli Saraf	Dokter Ahli Bedah Saraf	Dokter Ahli Ortopedi	Dokter Ahli Urologi	Dokter Ahli Patologi Anatomi	Dokter Ahli Patologi Forensik	Dokter Ahli Rehabilitasi Medik	Dokter Ahli Lainnya	Dokter Gigi	Total
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
1	Dep.Kes																							
2	Pemda Tk. I (Propinsi)																							
3	Pemda Tk. II (Kab/Kodya)																							
4	Depdikbud																							
5	ABRI																							
6	Dep.Lainnya																							
7	Swasta																							
	Total																							

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DEPKES INDONESIA

Date: 29-07-1992
Page: 1
Prog: RRDTKJ

DATA KEADAAN KETENAGAAN RUMAH SAKIT (RL4)

Nama Rumah Sakit : RSU Tegalyoso

6. TENAGA MENURUT JENIS DAN GOLONGAN GAJI PGPS 1968

No. Kode Rumah Sakit : 3310015

Jenis Tenaga Menurut Golongan Gaji	PNS DepKes Diperkerjakan (Gaji Setjen)	PNS DepKes Diperkerjakan (Gaji Yanmed)	PNS DepKes Diperkerjakan (Gaji Kanwil)	PNS DepKes (RS Vertikal)	PNS DepKes Diperbantukan	PNS Daerah (TK.I & TK.II)	PNS Depdikbud	ABRI termasuk PNS	PNS Dep. Lain termasuk BUMN	Non Pegawai Negeri (Swasta)	Tenaga Part time *) PNS Depkes	PNS Daerah (TK.I & TK.II)	PNS Depdikbud	ABRI/PNS	PNS Dep. Lain	Sub Total	Honorer (belum ada pengangkatan)	Total
1. TENAGA MEDIK																		
GOLONGAN I																		
GOLONGAN II	1																	
GOLONGAN III																		
GOLONGAN IV		2																
SUBTOTAL TENAGA MEDIK	1	2			1						1							
2. TENAGA PARAMEDIK PERAWATAN																		
GOLONGAN I																		
GOLONGAN II																		
GOLONGAN III																		
GOLONGAN IV																		
SUBTOTAL TENAGA PARAMEDIK PERAWATAN																		
3. TENAGA PARAMEDIK NON PERAWATAN																		
GOLONGAN I																		
GOLONGAN II																		
GOLONGAN III																		
GOLONGAN IV																		
SUBTOTAL TENAGA PARAMEDIK NON PERAWATAN																		
4. TENAGA NON MEDIK																		
GOLONGAN I																		
GOLONGAN II																		
GOLONGAN III																		
GOLONGAN IV																		
SUBTOTAL TENAGA NON MEDIK																		
GOLONGAN I																		
GOLONGAN II	1																	
GOLONGAN III																		
GOLONGAN IV		2																
TOTAL GOLONGAN (I - IV)	1	2			1						1							

DATA INDIVIDUAL KETENAGAAN RUMAH SAKIT (RL4a)

Keadaan per 31 Juli 1992

Nama Rumah Sakit : RSU Tegalyoso

No. Kode RS : 331005

I. DATA PRIBADI

1. Nama : dr. Bonar
2. Tempat/Tanggal Lahir : Cianjur/01-01-1950
3. Jenis Kelamin : 1 (LAKI-LAKI)
4. Status : 1 (Kawin)
5. Agama : 3 (Islam)
6. Nomor Induk
   - 6a. Jenis : NIP
   - 6b. Nomor : 12
7. Instansi Induk : 01 (Dep. Dalam Negeri)
8. Status Kepegawaian : 1 (PNS Pusat (Depkes))

II. DATA PEKERJAAN DI RUMAH SAKIT

9. Status Ketenagaan : 2 (Capeg)
10a. Jabatan Struktural :
10b. Terhitung (TMT) : 20-12-1981
10c. Nomor SK. : 81/0123456789
   Tanggal SK. : 02-12-1981
11. Jabatan Fungsional/Profesi : 1.01 (Dokter Asisten Ahli)
12. Bidang Tugas :
13. Pengangkatan Pertama
   - 13a. Pangkat : 3D (Penata Tk.I)
   - 13b. Terhitung (TMT) : 01-01-1982
   - 13c. Nomor SK. : 001
     Tanggal SK. : 01-02-1979
   - 13d. Ijazah : Tahun 1992
   - 13e. Nama Sekolah :
14a. Pangkat Sekarang : 4C (Pembina Utama Muda)
14b. Terhitung (TMT) : 01-02-1985
14c. Nomor SK. : 002
   Tanggal SK. : 01-03-1980
14d. Masa Kerja Golongan : 12/ 4 (Tahun/Bulan)
15. Instansi yang membayar gaji : 2 (DirJen. DepKes)

III. PENDIDIKAN LANJUTAN : (Pendidikan sesudah pengangkatan pertama)

No.	Ijazah	Nama Sekolah/Akademi/Univ	Tahun selesai
1	Dokter Umum	Universitas Indonesia	1980
2	Dokter Umum Spesial	Universitas Indonesia	1982
3	Dokter Umum Spesial Ahli	Universitas Indonesia	

IV. LATIHAN JABATAN/KURSUS : (Minimum 100 jam pelajaran)

No.	Nama Latihan Jabatan/Kursus	Lamanya (dalam jam)	Tahun Selesai	DN/LN
1	Kursus Komputer	40	1980	LN
2	Kursus Akuntansi	60	1982	DN

V. PENGALAMAN KERJA

No.	Unit Organisasi	Jabatan	Sejak Tgl/Bln/Thn	Sampai Tgl/Bln/Thn
1	RS Persahabatan	Dokter Asisten	01-01-1980	01-10-1981

Mengetahui Direktur Rumah Sakit :

Nama Terang : .....

Tanda Tangan : .....

BEST AVAILABLE COPY

SECTION TWO

HOSPITAL ACCOUNTING SYSTEM

Periode 07-92 RS Tegalyoso Tgl 28

Perusahaan 01
Kode Sumber AR
No.Voucher 002
Tgl.Transaksi 10-07-92
Tgl.Entri 10-07-92
Tempo 30
Batch
Operator MANAGER
Proses

No.Akun	Sub	Keterangan	No.Dokument	D/K	Jumlah
133	0001	Ali Makmur	12345678	D	50,000.00
133	0001	Badu Alim	12345679	D	200,000.00
133	0001	Amir	12345680	D	35,000.00
45	47	Medical Check Up		K	285,000.00

Acc# :45 - Pendapatan Bahan/Obat/Alat
Sub GL:47 -Medical Check Up
No.Dok:

Db	285,000.00
Kr	285,000.00
Tot	0.00

Entri Koreksi Atas Hps Cari Sblm Brk Last Z Pro Rev Unpro Info GL Menu Tamat
Menampilkan informasi dari kode-kode transaksi.

RS Tegalyoso

Daftar Kode Perkiraan Buku Besar

Tgl : 29-07-1992
Hal : 1

Kode	Nama Perkiraan	TL	Tipe	BT	Dok	Inv
1	Aktiva	1	Total			
11	Kas	2	Total			
111	Kas Kecil	3	Jurnal			
112	Kas Dana DIK	3	Jurnal			
113	Kas Dana DIP	3	Jurnal			
114	Kas Dana Khusus	3	Jurnal			
12	Bank	2	Total			
121	Bank A	3	Jurnal			
122	Bank B	3	Jurnal			
123	Bank C	3	Jurnal			
124	Bank D	3	Jurnal			
125	Bank E	3	Jurnal			
126	Bank F	3	Jurnal			
13	Piutang	2	Total			
131	Dana DIK yang akan diterima	3	Jurnal			
132	Dana DIP yang akan diterima	3	Jurnal			
133	Piutang Jaminan Perusahaan (Kontraktor)	3	Jurnal	C	Y	
134	Piutang PHB	3	Jurnal			
135	Piutang Pasien Masih Dirawat	3	Jurnal			
136	Piutang Pasien Umum	3	Jurnal			
137	Piutang Pegawai	3	Jurnal			
138	Piutang Lain-lain	3	Jurnal			
139	Cadangan Kerugian Piutang	3	Jurnal			
14	Uang Muka	2	Total			
141	Uang muka Dinas (UYHD) Anggaran	3	Jurnal			
142	Uang Muka Pada Rekanan	3	Jurnal			
15	Persediaan	2	Total			
151	Persediaan Obat-obatan	3	Jurnal			
152	Persediaan Bahan/Alat Kesehatan	3	Jurnal			
153	Persediaan Bahan Laboratorium	3	Jurnal			
154	Persediaan Bahan Kimia Non Laboratorium	3	Jurnal			
155	Persediaan Bahan Radiologi/Nuklir	3	Jurnal			
156	Persediaan Bahan Medis lainnya	3	Jurnal			
157	Persediaan Bahan Dapur	3	Jurnal			
158	Persediaan Administrasi	3	Jurnal			
159	Persediaan Suku Cadang/Barang Tehnik	3	Jurnal			
16	Biaya Dibayar Dimuka	2	Total			
161	Gaji Honor Dibayar Dimuka	3	Jurnal			
162	Premi Asuransi Dibayar Dimuka	3	Jurnal			
163	Biaya Lain-lain Dibayar Dimuka	3	Jurnal			
164	Setoran Masa PPh pasal 21	3	Jurnal			
17	Aktiva Tetap Berwujud	2	Total			
171	Tanah	3	Jurnal			
172	Bangunan	3	Jurnal			
173	Mesin-Mesin dan Peralatan	3	Jurnal			
174	Alat Medis/Kedokteran	3	Jurnal			
175	Furnitures & Fixtures	3	Jurnal			
176	Kendaraan Bermotor	3	Jurnal			
177	Peralatan Kantor & Komputer	3	Jurnal			
178	Peralatan Lain-lain	3	Jurnal			
179	Akumulasi Penyusutan Aktiva	3	Jurnal			
18	Aktiva Tak Berwujud	2	Total			
181	Biaya Administrasi Pendirian	3	Jurnal			
182	Biaya Tenaga Ahli/Konsultan	3	Jurnal			
183	Biaya Penelitian & Pengembangan	3	Jurnal			

RS Tegalyoso

B U K U B E S A R
Periode : Juli 1992

Tgl : 29-07-1992
Hal : 1

Kode No.	Nama Perkiraan / Sumb.	Voucher	Tgl.Entri	Tgl.Trans	Kode Transaksi	Keterangan		Nomor Dokument	Debit	Kredit	Upd
111	Kas Kecil										
1.	KAS	001	10-07-1992	10-07-1992	111	Kertas Tisue		KAS 001	0	37,500	11000
							***	Total Mutasi	0	37,500	
							***	Saldo Awal	0		
							***	Saldo Akhir	-37,500		
121	Bank A										
1.	BANK	001	25-07-1992	25-07-1992	121	Bank A		SETOR 00001	750,000	0	11000
							***	Total Mutasi	750,000	0	
							***	Saldo Awal	0		
							***	Saldo Akhir	750,000		
133	Piutang Jaminan Perusahaan (Kontraktor)										
1.	AR	001	10-07-1992	10-07-1992	133	Ali Makmur		12345678	120,000	0	11100
2.	AR	001	10-07-1992	10-07-1992	133	Badu Alim		12345679	150,000	0	11100
3.	AR	001	10-07-1992	10-07-1992	133	Amir		12345680	1,200,000	0	11100
4.	AR	002	10-07-1992	10-07-1992	133	Ali Makmur		12345678	50,000	0	11100
5.	AR	002	10-07-1992	10-07-1992	133	Badu Alim		12345679	200,000	0	11100
6.	AR	002	10-07-1992	10-07-1992	133	Amir		12345680	35,000	0	11100
7.	BANK	001	25-07-1992	25-07-1992	133	Amir		12345680	0	500,000	11100
8.	BANK	001	25-07-1992	25-07-1992	133	Ali Makmur		12345678	0	100,000	11100
9.	BANK	001	25-07-1992	25-07-1992	133	Badu Alim		12345679	0	150,000	11100
							***	Total Mutasi	1,755,000	750,000	
							***	Saldo Awal	0		
							***	Saldo Akhir	1,005,000		
42	Pendapatan Akomodasi										
1.	AR	001	10-07-1992	10-07-1992	42	Ruang VIP		.	0	1,470,000	11000
							***	Total Mutasi	0	1,470,000	
							***	Saldo Awal	0		
							***	Saldo Akhir	-1,470,000		
45	Pendapatan Bahan/Obat/Alat										
1.	AR	002	10-07-1992	10-07-1992	45	Medical Check Up		.	0	285,000	11000
							***	Total Mutasi	0	285,000	
							***	Saldo Awal	0		
							***	Saldo Akhir	-285,000		
521	Biaya Bahan/Alat Administrasi										
1.	KAS	001	10-07-1992	10-07-1992	521	Pensil dan Stabilo		KAS 001	25,000	0	11000
							***	Total Mutasi	25,000	0	
							***	Saldo Awal	0		
							***	Saldo Akhir	25,000		
522	Biaya Barang Cetakan										
1.	KAS	001	10-07-1992	10-07-1992	522	Photocopy Buku		KAS 001	12,500	0	11000

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RS Tegalyoso

Summary Trial Balance
Periode: Juli 1992

Tgl : 29-07-1992
Hal : 1

Kode	Nama Perkiraan	Saldo Awal	Debit	Kredit	Saldo Aknir
1	Aktiva	0.00	2,505,000.00	787,500.00	1,717,500.00
11	Kas	0.00	0.00	37,500.00	-37,500.00
111	Kas Kecil	0.00	0.00	37,500.00	-37,500.00
112	Kas Dana DIK	0.00	0.00	0.00	0.00
113	Kas Dana DIP	0.00	0.00	0.00	0.00
114	Kas Dana Khusus	0.00	0.00	0.00	0.00
12	Bank	0.00	750,000.00	0.00	750,000.00
121	Bank A	0.00	750,000.00	0.00	750,000.00
122	Bank B	0.00	0.00	0.00	0.00
123	Bank C	0.00	0.00	0.00	0.00
124	Bank D	0.00	0.00	0.00	0.00
125	Bank E	0.00	0.00	0.00	0.00
126	Bank F	0.00	0.00	0.00	0.00
13	Piutang	0.00	1,755,000.00	750,000.00	1,005,000.00
131	Dana DIK yang akan diterima	0.00	0.00	0.00	0.00
132	Dana DIP yang akan diterima	0.00	0.00	0.00	0.00
133	Piutang Jaminan Perusahaan (Kontraktor)	0.00	1,755,000.00	750,000.00	1,005,000.00
134	Piutang PHB	0.00	0.00	0.00	0.00
135	Piutang Pasien Masih Dirawat	0.00	0.00	0.00	0.00
136	Piutang Pasien Umum	0.00	0.00	0.00	0.00
137	Piutang Pegawai	0.00	0.00	0.00	0.00
138	Piutang Lain-lain	0.00	0.00	0.00	0.00
139	Cadangan Kerugian Piutang	0.00	0.00	0.00	0.00
14	Uang Muka	0.00	0.00	0.00	0.00
141	Uang Muka Dinas (UYHD) Anggaran	0.00	0.00	0.00	0.00
142	Uang Muka Pada Rekanan	0.00	0.00	0.00	0.00
15	Persediaan	0.00	0.00	0.00	0.00
151	Persediaan Obat-obatan	0.00	0.00	0.00	0.00
152	Persediaan Bahan/Alat Kesehatan	0.00	0.00	0.00	0.00
153	Persediaan Bahan Laboratorium	0.00	0.00	0.00	0.00
154	Persediaan Bahan Kimia Non Laboratorium	0.00	0.00	0.00	0.00
155	Persediaan Bahan Radiologi/Nuklir	0.00	0.00	0.00	0.00
156	Persediaan Bahan Medis lainnya	0.00	0.00	0.00	0.00
157	Persediaan Bahan Dapur	0.00	0.00	0.00	0.00
158	Persediaan Administrasi	0.00	0.00	0.00	0.00
159	Persediaan Suku Cadang/Barang Tehnik	0.00	0.00	0.00	0.00
16	Biaya Dibayar Dimuka	0.00	0.00	0.00	0.00
161	Gaji Honor Dibayar Dimuka	0.00	0.00	0.00	0.00
162	Premi Asuransi Dibayar Dimuka	0.00	0.00	0.00	0.00
163	Biaya Lain-lain Dibayar Dimuka	0.00	0.00	0.00	0.00
164	Setoran Masa PPh pasal 21	0.00	0.00	0.00	0.00
17	Aktiva Tetap Berwujud	0.00	0.00	0.00	0.00
171	Tanah	0.00	0.00	0.00	0.00
172	Bangunan	0.00	0.00	0.00	0.00
173	Mesin-Mesin dan Peralatan	0.00	0.00	0.00	0.00
174	Alat Medis/Kedokteran	0.00	0.00	0.00	0.00
175	Furnitures & Fixtures	0.00	0.00	0.00	0.00
176	Kendaraan Bermotor	0.00	0.00	0.00	0.00
177	Peralatan Kantor & Komputer	0.00	0.00	0.00	0.00
178	Peralatan Lain-lain	0.00	0.00	0.00	0.00
179	Akumulasi Penyusutan Aktiva	0.00	0.00	0.00	0.00
18	Aktiva Tak Berwujud	0.00	0.00	0.00	0.00
181	Biaya Administrasi Pendirian	0.00	0.00	0.00	0.00
182	Biaya Tenaga Ahli/Konsultan	0.00	0.00	0.00	0.00
183	Biaya Penelitian & Pengembangan	0.00	0.00	0.00	0.00

RS Tegalyoso

Tanggal: 29-07-1992
Halaman: 1

N E R A C A
Per : 29 Juli 1992
HELLO

A K T I V A

	Akhir Periode Sekarang	Akhir Periode Lalu
AKTIVA LANCAR	0.00	0.00
Kas	(37,500.00)	0.00
Bank	750,000.00	0.00
Piutang	1,005,000.00	0.00
Uang Muka	0.00	0.00
Persediaan	0.00	0.00
Biaya Dibayar Dimuka	0.00	0.00
* Total Aktiva Lancar	1,717,500.00	0.00
AKTIVA TETAP BERWUJUD		
Tanah	0.00	0.00
Bangunan	0.00	0.00
Mesin-Mesin dan Peralatan	0.00	0.00
Alat Medis/Kedokteran	0.00	0.00
Furnitures & Fixtures	0.00	0.00
Kendaraan Bermotor	0.00	0.00
Peralatan Kantor & Komputer	0.00	0.00
Peralatan Lain-lain	0.00	0.00
Akumulasi Penyusutan Aktiva	0.00	0.00
* Total Aktiva Tetap Berwujud	0.00	0.00
AKTIVA TAK BERWUJUD		
Biaya Administrasi Pendirian	0.00	0.00
Biaya Tenaga Ahli/Konsultan	0.00	0.00
Biaya Penelitian & Pengembangan	0.00	0.00
Amortisasi Aktiva Tidak Berwujud	0.00	0.00
* Total Aktiva Tak Berwujud	0.00	0.00
AKTIVA TETAP DALAM PROSES PEMBANGUNAN		
Bangunan Dalam Proses/Pelaksanaan	0.00	0.00
Aktiva Tetap Dalam Perjalan	0.00	0.00
* Total Aktiva Tetap dlm Pembangunan	0.00	0.00
TOTAL AKTIVA LANCAR DAN TETAP	0.00	0.00

KEWAJIBAN DAN MODAL SENDIRI

	Akhir Periode Sekarang	Akhir Periode Lalu
HUTANG		
Hutang Jangka Pendek	0.00	0.00
Hutang Jangka Panjang	0.00	0.00
Hutang Lain-lain	0.00	0.00
* Total Hutang	0.00	0.00
DANA (EQUITY)		
Dana Rutin	0.00	0.00
Dana Pembangunan	0.00	0.00
Dana Permulaan	0.00	0.00
Dana Donasi	0.00	0.00
Dana Lain-lain	0.00	0.00
Saldo Surplus/Defisit		
Saldo Hasil Usaha Tahun Lalu	0.00	0.00
Saldo Hasil Usaha Tahun Berjalan	0.00	0.00
* Total Dana (Equity)	0.00	0.00
TOTAL HUTANG DAN DANA	0.00	0.00

RS Tegalyoso

Tanggal: 29-07-1992
Halaman: 1

PERHITUNGAN RUGI-LABA
Periode: 29 Juli 1992

Uraian	s/d Bulan Ini		Bulan Ini	
	Jumlah	%	Jumlah	%
PENDAPATAN USAHA (REVENUE)				
Pendapatan Pemeriksaan/Konsul Dokter	0.00		0.00	
Pendapatan Akomodasi	1,470,000.00		1,470,000.00	
Pendapatan Tindakan	0.00		0.00	
Pendapatan Diagnostik	0.00		0.00	
Pendapatan Bahan/Obat/Alat	285,000.00		285,000.00	
Pendapatan Lain-lain	0.00		0.00	
Potongan Pendapatan Jasa Medik&Anestes	0.00		0.00	
Potongan/Keringanan/Pembebasan	0.00		0.00	
Perkiraan Belum Dapat Diklasifikasi'an	0.00		0.00	
* Total Pendapatan Usaha (Revenue)	1,755,000.00		1,755,000.00	
BIAYA USAHA				
Biaya Gaji/Honor/Lembur/Tunjangan	0.00		0.00	
Biaya Administrasi	(37,500.00)		(37,500.00)	
Biaya Utilitas & Bahan Bakar	0.00		0.00	
Biaya Bahan Medis	0.00		0.00	
Biaya Bahan Non Medis	0.00		0.00	
Biaya Perjalanan Dinas & Pendidikan	0.00		0.00	
Biaya Pemeliharaan	0.00		0.00	
Biaya Penyusutan,Amortisasi&Penghapusan	0.00		0.00	
* Total Biaya Usaha	(37,500.00)		(37,500.00)	
BIAYA-BIAYA YANG DIALOKASIKAN	0.00		0.00	
PENDAPATAN LAIN-LAIN				
Pendapatan Non Operasional	0.00		0.00	
BIAYA LAIN-LAIN				
Biaya Non Operasional	0.00		0.00	
HASIL USAHA	1,717,500.00		1,717,500.00	

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RS Tegalyoso

Tanggal: 29-07-1992
Halaman: 1

Perincian Saldo Kas dan Bank
Per: 29 Juli 1992

No.	Perkiraan	Keterangan	Saldo Awal	Mutasi	Saldo Akhir
1	111	Kas Kecil	0.00	(37,500.00)	(37,500.00)
2	112	Kas Dana DIK	0.00	0.00	0.00
3	113	Kas Dana DIP	0.00	0.00	0.00
4	114	Kas Dana Khusus	0.00	0.00	0.00
		Kas	0.00	(37,500.00)	(37,500.00)
1	121	Bank A	0.00	750,000.00	750,000.00
2	122	Bank B	0.00	0.00	0.00
3	123	Bank C	0.00	0.00	0.00
4	124	Bank D	0.00	0.00	0.00
5	125	Bank E	0.00	0.00	0.00
6	126	Bank F	0.00	0.00	0.00
		Bank	0.00	750,000.00	750,000.00
		* * T O T A L * *	0.00	712,500.00	712,500.00

RS Tegalyoso

Tanggal: 29-07-1992
Halaman: 1

Laporan Perincian Persediaan
Per: 29 Juli 1992

No.	Perkiraan	Keterangan	Saldo Awal	Mutasi	Saldo Akhir
1	151	Persediaan Obat-obatan	0.00	0.00	0.00
2	152	Persediaan Bahan/Alat Kesehatan	0.00	0.00	0.00
3	153	Persediaan Bahan Laboratorium	0.00	0.00	0.00
4	154	Persediaan Bahan Kimia Non Laboratorium	0.00	0.00	0.00
5	155	Persediaan Bahan Radiologi/Nuklir	0.00	0.00	0.00
6	156	Persediaan Bahan Medis lainnya	0.00	0.00	0.00
7	157	Persediaan Bahan Dapur	0.00	0.00	0.00
8	158	Persediaan Administrasi	0.00	0.00	0.00
9	159	Persediaan Suku Cadang/Barang Tehnik	0.00	0.00	0.00
		* * T O T A L * *	0.00	0.00	0.00

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RS Tegalyoso

Daftar Piutang Pasien Jaminan Perusahaan
Pertanggal: 29 Juli 1992

Tanggal: 29-07-1992
Halaman: 1

No.	Kode	No.Register	Tgl.Trans	Jth.Tempo	Keterangan	Jumlah	Umur 1 - 30	Umur 31 - 60	Umur 61 - 90	Umur 90 - dst	Tanggal	Pembayaran	Saldo
1	0001	12345678	10-07-1992	09-08-1992	Ali Makmur	170,000.00					25-07-1992	100,000.00	70,000.00
2	0001	12345679	10-07-1992	09-08-1992	Badu Alim	350,000.00					25-07-1992	150,000.00	200,000.00
3	0001	12345680	10-07-1992	09-08-1992	Amir	1,235,000.00					25-07-1992	500,000.00	735,000.00
					PT. Maju Jaya	1,755,000.00	0.00	0.00	0.00	0.00		750,000.00	1,005,000.00
						1,755,000.00	0.00	0.00	0.00	0.00		750,000.00	1,005,000.00

RS Tegalyoso

Daftar Piutang Pasien Jaminan Perusahaan
Pertanggal: 29 Juli 1992

Tanggal: 29-07-1992
Halaman: 1

No.	Kode	Nama Perusahaan	Saldo Awal	Mutasi	Saldo Akhir
1	0001	PT. Maju Jaya	0.00	1,005,000.00	1,005,000.00
			0.00	1,005,000.00	1,005,000.00

RS Tegalyoso

Laporan Transaksi per Kode Sumber

Tgl : 29-07-1992
Hal : 1

Sumber	Voucher / Keterangan	Tgl.Entri	Tgl.Trans.	Tempo	Referensi / Nomor Dokument	Batch / Perkiraan	Proses / Buku Tamb.	Debit	Kredit	Upd
AR	061	10-07-1992	10-07-1992	30	MANAGER					
	All Makmur				12345678	133	0001	120,000.00		11100
	Badu Alim				12345679	133	0001	150,000.00		11100
	Amir				12345680	133	0001	1,200,000.00		11100
	Ruang VIP				.	42	01		1,470,000.00	11000
AR	002	10-07-1992	10-07-1992	30	MANAGER					
	All Makmur				12345678	133	0001	50,000.00		11100
	Badu Alim				12345679	133	0001	200,000.00		11100
	Amir				12345680	133	0001	35,000.00		11100
	Medical Check Up				.	45	47		285,000.00	11000
								1,755,000.00	1,755,000.00	

Jumlah Transaksi : 8

RS Tegalyoso

Daftar Kode Buku Tambahan

Tgl : 29-07-1992
Hal : 1

Tabel: Daftar Pelanggan

No.	Tipe	Kode	Nama Perusahaan
1	C	0001	PT. Maju Jaya
2	C	0002	PT. Trijasa
3	C	0003	PT. Inti Inforama Sejahtera
4	C	0004	PT. PQM
5	C	0005	PT. Trimandiri

RS Tegalyoso

Daftar Tipe Buku Tambahan

Tgl : 29-07-1992
Hal : 1

No	Tipe	Judul Tabel Buku Tambahan	Nama Atribut	Alamat
1	C	Daftar Pelanggan	Nama Perusahaan	Y
2	D	Unit Pelayanan	Unit Pelayanan	
3	S	Daftar Supplier	Nama Perusahaan	Y

SECTION THREE

INFORMATION SYSTEM TABLES

Tabel Tarip Pelayanan / Tindakan

1. Tarip Karcis Rawat Jalan

Kode Pelayanan	Deskripsi	Bahan/Alat	Jasa RS	Jasa Medik
01.01.1	Dengan Rujukan	0	500	0
01.01.2	Bukan rujukan Puskesmas / Rujukan Swasta	0	2,000	0
01.02	Karcis Gawat Darurat	0	1,000	0

Tabel Tarip Pelayanan / Tindakan

2. Tarip Rawat Nginap

Kode Pelayanan	Deskripsi	Bahan/Alat	Jasa RS	Jasa Medik
02.01	Akomodasi Kelas IIIA	0	2,500	0
02.02	Akomodasi Kelas III Jaminan Kantor	0	3,500	0
02.03	Akomodasi Kelas II	0	7,500	0
02.04	Akomodasi Kelas I	0	21,000	0
02.05.1	Akomodasi Ruang C.E.U	0	15,000	0
02.05.2	Akomodasi Ruang High Care	0	15,000	0
02.06	Akomodasi Kelas VIP B	0	50,000	0
02.07	Akomodasi Kelas VIP A	0	60,000	0
02.08.1	Akomodasi Perawatan Bayi - Baru Lahir	0	5,000	0
02.08.2	Akomodasi Perawatan Bayi - Rooming In Kls IIIA	0	1,250	0
02.08.3	Perawatan Bayi - Rooming In Kls III Jaminan Kantor	0	1,750	0
02.08.4	Perawatan Bayi - Rooming In Kls II	0	3,750	0
02.08.5	Perawatan Bayi - Rooming In Kls I	0	10,500	0
02.08.6	Perawatan Bayi - Rooming In Ruang C.E.U	0	7,500	0
02.08.7	Perawatan Bayi - Rooming In Ruang High Care	0	7,500	0
02.08.8	Perawatan Bayi - Rooming In Kls VIP B	0	25,000	0
02.08.9	Perawatan Bayi - Rooming In Kls VIP A	0	30,000	0

Tabel Tarip Pelayanan / Tindakan

3. Tarip Jasa Medik Visite / Konsultasi

Kode Pelayanan	Deskripsi	Bahan/Alat	Jasa RS	Jasa Medik
03.01	Kelas IIIA	0	1,500	0
03.02	Kelas III Jaminan Kantor	0	2,500	0
03.03	Kelas II	0	4,500	0
03.04	Kelas I	0	7,500	0
03.05.1	Ruang C.E.U	0	7,500	0
03.05.2	Ruang High Care	0	7,500	0
03.06	Kelas VIP B	0	15,000	0
03.07	Kelas VIP A	0	20,000	0
03.08.1	Bayi Baru Lahir Kls III	0	1,500	0
03.08.2	Bayi Baru Lahir Kls II	0	2,250	0
03.08.3	Bayi Baru Lahir Kls I	0	3,750	0
03.08.4	Bayi Baru Lahir Ruang C.E.U	0	3,750	0
03.08.5	Bayi Baru Lahir Ruang High Care	0	3,750	0
03.08.6	Bayi Baru Lahir VIP B	0	7,500	0
03.08.7	Bayi Baru Lahir VIP A	0	10,000	0

Tabel Tarip Pelayanan / Tindakan

4. Tarip Pemeriksaan Laboratorium Klinik

Kode Pelayanan	Deskripsi	Bahan/Alat	Jasa RS	Jasa Medik
04.02.1.01.01.1	L E D - Kls III	300	150	100
04.02.1.01.01.2	L E D - Kls II	300	150	150
04.02.1.01.01.3	L E D - Kls I	300	150	300
04.02.1.01.01.4	L E D - Kls VIP	300	150	450
04.02.1.01.02.1	Hematokrit - Kls III	300	150	100
04.02.1.01.02.2	Hematokrit - Kls II	300	150	150
04.02.1.01.02.3	Hematokrit - Kls I	300	150	300
04.02.1.01.02.4	Hematokrit - Kls VIP	300	150	450
04.02.1.01.03.1	H B - Kls III	300	150	100
04.02.1.01.03.2	H B - Kls II	300	150	150
04.02.1.01.03.3	H B - Kls I	300	150	300
04.02.1.01.03.4	H B - Kls VIP	300	150	450

Tabel Tarip Pelayanan / Tindakan

5. Tarip Pemeriksaan Laboratorium Patologi Anatomi

Kode Pelayanan	Deskripsi	Bahan/Alat	Jasa RS	Jasa Medik
05.02.1.01.01.1	Sitologi - Kls III	3,000	2,000	2,000
05.02.1.01.01.2	Sitologi - Kls II	3,000	2,000	4,000
05.02.1.01.01.3	Sitologi - Kls I	3,000	2,000	7,000
05.02.1.01.01.4	Sitologi - Kls VIP	3,000	2,000	10,000
05.02.2.01.01.1	Sistologi 3 seri - Kls Iii	6,000	3,000	3,000
05.02.2.01.01.2	Sistologi 3 seri - Kls II	6,000	3,000	5,000
05.02.2.01.01.3	Sistologi 3 seri - Kls I	6,000	3,000	8,000
05.02.2.01.01.4	Sistologi 3 seti - Kls VIP	6,000	3,000	12,000
05.02.2.01.02.1	Histopathologi - Kelenjar Getah Bening	6,000	3,000	3,000
05.02.2.01.02.2	Histopathologi - Kelenjar Getah Bening	6,000	3,000	5,000
05.02.2.01.02.3	Histopathologi - Kelenjar Getah Bening	6,000	3,000	8,000
05.02.2.01.02.4	Histopathologi - Kelenjar Getah Bening	6,000	3,000	12,000

Tabel Tarip Pelayanan / Tindakan

6. Tarip Pemeriksaan Radio Diagnostik

Kode Pelayanan	Deskripsi	Bahan/Alat	Jasa RS	Jasa Medik
06.01.1.01.01.1	Photo Gigi Biasa	2,000	1,000	600
06.01.1.01.01.2	Photo Gigi Biasa	2,000	1,000	900
06.01.1.01.01.3	Photo Gigi Biasa	2,000	1,000	900
06.01.1.01.01.4	Photo Gigi Biasa	2,000	1,000	900
06.01.2.01.01.1	Kepala (Sinus Mastoid)	5,000	2,500	1,500
06.01.2.01.01.2	Kepala (Sinus Mastoid)	5,000	2,500	2,500
06.01.2.01.01.3	Kepala (Sinus Mastoid)	5,000	2,500	3,000
06.01.2.01.01.4	Kepala (Sinus Mastoid)	5,000	2,500	4,500

Tabel Tarip Pelayanan / Tindakan

7. Tarip Pemeriksaan Diagnostik Elektromedik

Kode Pelayanan	Deskripsi	Bahan/Alat	Jasa RS	Jasa Medik
07.01.1.01.01.1	E.C.G	1,500	1,500	1,500
07.01.1.01.01.2	E C.G	1,500	1,500	4,000
07.01.1.01.01.3	E.C.G	1,500	1,500	7,500
07.01.1.01.01.4	E.C.G	1,500	1,500	10,000
07.01.2.01.01.1	USG Mata tanpa Film	3,000	3,000	4,000
07.01.2.01.01.2	USG Mata tanpa Film	3,000	3,000	6,000
07.01.2.01.01.3	USG Mata tanpa Film	3,000	3,000	8,000
07.01.2.01.01.4	USG Mata tanpa Film	3,000	3,000	12,000

Tabel Tarip Pelayanan / Tindakan

8. Tarip Pemeriksaan Diagnostik dengan Alat Non Elektromedik

Kode Pelayanan	Deskripsi	Bahan/Alat	Jasa RS	Jasa Medik
08.01.1.01.01.1	Anoscopy	1,000	1,000	1,000
08.01.1.01.01.2	Anoscopy	1,000	1,000	1,500
08.01.1.01.01.3	Anoscopy	1,000	1,000	2,000
08.01.1.01.01.4	Anoscopy	1,000	1,000	2,000
08.01.2.01.01.1	Sigmoidoscopy	1,000	1,000	3,000
08.01.2.01.01.2	Sigmoidoscopy	1,000	1,000	4,000
08.01.2.01.01.3	Sigmoidoscopy	1,000	1,000	5,000
08.01.2.01.01.4	Sigmoidoscopy	1,000	1,000	8,000

Tabel Tarip Pelayanan / Tindakan

9. Tarip Persalinan

Kode Pelayanan	Deskripsi	Bahan/Alat	Jasa RS	Jasa Medik
09.01.1.01.01.1	Eksplorasi luka tusuk	1,500	1,500	1,000
09.01.1.01.01.2	Eksplorasi luka tusuk	1,500	1,500	1,500
09.01.1.01.01.3	Eksplorasi luka tusuk	1,500	1,500	2,500
09.01.1.01.01.4	Eksplorasi luka tusuk	1,500	1,500	5,000
09.01.2.01.01.1	Vena Seksi	3,000	2,000	3,000
09.01.2.01.01.2	Vena Seksi	3,000	2,000	5,000
09.01.2.01.01.3	Vena Seksi	3,000	2,000	7,000
09.01.2.01.01.4	Vena Seksi	3,000	2,000	15,000

Tabel Tarip Pelayanan / Tindakan

10. Tarip Persalinan

Kode Pelayanan	Deskripsi	Bahan/Alat	Jasa RS	Jasa Medik
10.01.1	Persalinan - Normal	15,000	15,000	30,000
10.01.2	Persalinan - Normal	15,000	20,000	50,000
10.01.3	Persalinan - Normal	15,000	30,000	100,000
10.01.4	Persalinan - Normal	15,000	50,000	200,000
10.02.1	Persalinan - Dengan Tindakan	25,000	25,000	60,000
10.02.2	Persalinan - Dengan Tindakan	25,000	30,000	100,000
10.02.3	Persalinan - Dengan Tindakan	25,000	40,000	200.000
10.02.4	Persalinan - Dengan Tindakan	25,000	60,000	400,000

Tabel Tarip Pelayanan / Tindakan

11. Tarip Tindakan Medik (Medical Intervention)

Kode Pelayanan	Deskripsi	Bahan/Alat	Jasa RS	Jasa Medik
11.01.1.01.01.1	Pasang Schoorsteen	0	500	1,000
11 01.1.01.01.2	Pasang Schoorsteen	0	500	2,000
11.01.1.01.01.3	Pasang Schoorsteen	0	500	3,000
11.01.1.01.01.4	Pasang Schoorsteen	0	500	8,000
11.01.2.01.01.1	Pasang Infus	0	500	1,000
11.01.2.01.01.2	Pasang Infus	0	500	3,000
11.01.2.01.01.3	Pasang Infus	0	500	5,000
11.01.2.01.01.4	Pasang Infus	0	500	10,000

Tabel Tarip Pelayanan / Tindakan

12. Tarip Tindakan Bedah di Kamar Operasi

Kode Pelayanan	Deskripsi	Bahan/Alat	Jasa RS	Jasa Medik
12.01.1.01.01.1	Insisi	20,000	7,500	25,000
12.01.1.01.01.2	Insisi	20,000	10,000	40,000
12.01.1.01.01.3	Insisi	20,000	15,000	60,000
12.01.1.01.01.4	Insisi	20,000	25,000	80,000
12.02.1.01.01.1	Herniotomi elektif	60,000	20,000	75,000
12.02.1.01.01.2	Herniotomi elektif	60,000	25,000	125,000
12.02.1.01.01.3	Herniotomi elektif	60,000	35,000	200,000
12.02.1.01.01.4	Herniotomi elektif	60,000	50,000	300,000

Tabel Tarip Pelayanan / Tindakan

13. Tarip Tindakan Rehabilitasi Medik

Kode Pelayanan	Deskripsi	Bahan/Alat	Jasa RS	Jasa Medik
13.01.1.01.01.1	Latihan Phisik	0	500	500
13.01.1.01.01.2	Latihan Phisik	0	500	1,000
13.01.1.01.01.3	Latihan Phisik	0	500	1,500
13.01.1.01.01.4	Latihan Phisik	0	500	2,000
13.02.1.01.01.1	Tindakan dg 1 - 4 alat elektronik	0	1,000	1,000
13.02.1.01.01.2	Tindakan dg 1 - 4 alat elektronik	0	1,000	2,000
13.02.1.01.01.3	Tindakan dg 1 - 4 alat elektronik	0	1,000	3,000
13.02.1.01.01.4	Tindakan dg 1 - 4 alat elektronik	0	1,000	4,000
13.02.1.01.02.1	Hidrotherapi	0	1,000	1,000
13.02.1.01.02.2	Hidrotherapi	0	1,000	2,000
13.02.1.01.02.3	Hidrotherapi	0	1,000	3,000
13.02.1.01.02.4	Hidrotherapi	0	1,000	4,000

Tabel Tarip Pelayanan / Tindakan

14. Tarip Prosthetic Orthetic

Kode Pelayanan	Deskripsi	Bahan/Alat	Jasa RS	Jasa Medik
14.01.1.1	Milwauke Brace (XL)	420,000	20,000	40,000
14.01.1.2	Milwauke Brace (XL)	420,000	32,500	65,000
14.01.1.3	Milwauke Brace (XL)	420,000	42,500	85,000
14.01.1.4	Milwauke Brace (XL)	420,000	47,500	95,000
14.01.2.1	Milwauke Brace (M)	390,000	20,000	40,000
14.01.2.2	Milwauke Brace (M)	390,000	32,500	65,000
14.01.2.3	Milwauke Brace (M)	390,000	42,500	85,000
14.01.2.4	Milwauke Brace (M)	390,000	47,500	95,000

Tabel Tarip Pelayanan / Tindakan

15. Tarip Konsultasi

Kode Pelayanan	Deskripsi	Bahan/Alat	Jasa RS	Jasa Medik
15.01.1	Psikiatri	1,000	1,000	5,000
15.01.2	Psikiatri	1,000	1,000	7,500
15.01.3	Psikiatri	1,000	1,000	15,000
15.01.4	Psikiatri	1,000	1,000	30,000
15.02.1	Psikologi	0	1,000	5,000
15.02.2	Psikologi	0	1,000	7,500
15.02.3	Psikologi	0	1,000	15,000
15.02.4	Psikologi	0	1,000	30,000
15.03.1	Gizi Umum / Khusus	0	500	500
15.03.2	Gizi Umum / Khusus	0	500	1,000
15.03.3	Gizi Umum / Khusus	0	500	1,500
15.03.4	Gizi Umum / Khusus	0	500	4,000

Tabel Tarip Pelayanan / Tindakan

16. Tarip Perawatan Jenazah

Kode Pelayanan	Deskripsi	Bahan/Alat	Jasa RS	Jasa Medik
16.01	Fasilitas Jenazah	2,000	1,000	1,000
16.02	Simpan Jenazah (alat pendingin)	6,000	0	0

Tabel Obat

Kode Obat	Deskripsi	Satuan	Harga
17.01.0316	Adoria AC-17 50 mg/10 ml	amp	
17.01.0310	Adrenalin Bitartras	amp	
17.01.0319	Aminophyllin 2,4%	amp	
17.01.0381	Ampicillin 250 mg	flc	
17.01.0418	Ampicillin 500 mg	flc	
17.01.0385	Ampicillin 1000 mg	flc	
17.01.0323	Atropin sulfas 0,25	amp	
17.01.0327	Atropin sulfas 0,50	amp	
17.01.0326	Avil	amp	
17.01.0330	Buscopan	amp	
17.01.0333	Buscopan Comp	amp	
17.01.0339	Cardilanid	amp	
17.01.0341	Chloropromazin/Ethibernal	amp	
17.01.0349	Cortison Asetat	flc	
17.01.0421	Dexamethason/Fexadron/Kalmethason/Oradexon	amp	
17.01.0477	Diazepam/Paralium/Valium	amp	
17.01.0352	Difenhidrimin/Inadryl/Paradryl	flc	
17.01.0354	Dopamin 200 mg	amp	
17.01.0356	Effortil	amp	
17.01.0362	Erceecain 4%	amp	
17.01.0414	Extracain	amp	
17.01.0312	Eter Anestesi 100 ml	btl	
17.01.0344	Etil Klorida 100 ml/Chloraethyl	btl	
17.01.0375	Fluothane 250 ml/Halothane	btl	
17.01.0487	Furosemoda/Lasix/Orifur/Salurix	amp	
17.01.	Gentamisin/Garamycine	flc	
17.01.0388	Gluconas Calcicus 10%	amp	
17.01.0425	Glucose 40%	amp	
17.01.0373	Heparin	amp	
17.01.0372	Insulin	flc	
17.01.0391	Kalium Klorida/KCL	flc	
17.01.0394	Kemicetin Succinate	flc	
17.01.0396	Ketalar 100 mg	flc	
17.01.0405	Lidocain/Elocain	amp	
17.01.0404	Liver Extract 10 ml	flc	
17.01.0413	Methergin	amp	
17.01.0416	Meylon 7%	amp	
17.01.0420	Neurobiovit 9 ml	flc	
17.01.	Norcuron	amp	
17.01.0456	Oksitetrasiklin/Terramycin	flc	
17.01.0427	Papaverin HCL 40 mg	amp	
17.01.0441	Paramidon	flc	
17.01.0435	Pavulon	amp	
17.01.0439	Pentothal 0,5 G	amp	
17.01.0408	Phenobarbital 100 mg	amp	
17.01.0440	Procain HCL 4%	amp	
17.01.0431	Proc. Penicillin 3 juta kristal	flc	
17.01.0432	Proc. Penicillin 3 juta oil	flc	
17.01.0443	Prostigmin	amp	
17.01.	Reducdyn	amp	
17.01.0448	Streptomycin 1 g	flc	
17.01.0452	Succinyl Siccum	flc	
17.01.0454	Syntocinon IU 2 ml	amp	
17.01.0460	Urografin 76%	amp	
17.01.0463	Vitamin A 100.000 UI	amp	
17.01.0479	Vitamin B1 100 mg	amp	
17.01.0470	Vitamin B6 50 mg	amp	
17.01.	Vitamin B6 100 mg	amp	

Tabel Obat

Kode Obat	Deskripsi	Satuan	Harga
17.01.0464	Vitamin B12 1.000 mcg	amp	
17.01.0476	Vitamin Bcomplex 2 ml	amp	
17.01.0478	Vitamin Bcomplex 10 ml	flc	
17.01.0481	Vitamin C 200 mg 2 ml	amp	
17.01.0483	Vitamin K	amp	
17.02.0002	Acetosal 500 mg	tab	
17.02.0006	Adona AC - 17	tab	
17.02.0034	Aminophyllin 200 mg	kaps	
17.02.	Amoxicillin/Silamex 250 mg	kaps	
17.02.0028	Amoxicillin/Silamex 500 mg	kaps	
17.02.0026	Ampicillin 250 mg	kaps	
17.02.0023	Ampicillin 500 mg / forte	kaps	
17.02.0202	Antacid/Magnacid/Plantacid	tab	
17.02.	Antalgin	tab	
17.02.0035	Avil	tab	
17.02.	Becarbon/Norit	tab	
17.02.0038	Bactrim Adult/Sulfrim Adult	tab	
17.02.0042	Bellapeen/Ergophen	tab	
17.02.0046	Buscopan	tab	
17.02.0052	Buscopan Compositum	tab	
17.02.0150	Calcii Laktas/Lactas Calcic	tab	
17.02.0147	Chloramphenicol 250 mg	kaps	
17.02.0057	Chlorphenamin/CHlorphenon/CTM 4 mg	tab	
17.02.0060	Combantrin 125 mg	tab	
17.02.0152	Chlorpromasin/Largactil	tab	
17.02.	Danalgin	tab	
17.02.0071	Deconal	tab	
17.02.0166	Dexamethason/Fexadron/Kalmethason/Oradexon	tab	
17.02.0270	Diazepam/Paralium/Validex/Valium 2 mg	tab	
17.02.0272	Diazepam/Paralium/Validex/Valium 5 mg	tab	
17.02.0080	Digoxin 0,25 mg	tab	
17.02.	D.D.S 100 mg	tab	
17.02.	Diatab	tab	
17.02.0098	Efedrin 25 mg	tab	
17.02.0099	Efedrin 50 mg	tab	
17.02.0094	Enico	kaps	
17.02.0121	Erythromycin 250 mg	kaps	
17.02.0226	Etambutol/Bacbutol/Parabutol 250 mg	tab	
17.02.	Etambutol/Bacbutol/Parabutol 500 mg	tab	
17.02.0090	Etilfenilefrin/Effortil	tab	
17.02.0111	Extract Belladon 10 mg	tab	
17.02.0112	Extract Belladon 20 mg	tab	
17.02.0115	Folic Acid	tab	
17.02.0301	Furosemida/Lasix/Salurix	tab	
17.02.0124	Haemosol	kaps	
17.02.0126	H.C.T 25 mg	tab	
17.02.0127	H.C.T 50 mg	tab	
17.02.0135	Inderal 40 mg	tab	
17.02.0131	Isoniazid/I.N.H 100 mg	tab	
17.02.0165	Incidal	tab	
17.02.0155	Livron Bplex	tab	
17.02.0167	Methergin	tab	
17.02.0169	Mexaform	tab	
17.02.0170	Mogadon	tab	
17.02.	Mucosulvan/Exovon	tab	
17.02.0043	Natrium Bicarbonat/Bicarbonas Natricus 0,5 g	tab	
17.02.0044	Bicarbonas 1 gr	tab	
17.02.0194	Papaverin HCL 40 mg	tab	

a1

Tabel ICD / Diagnosa

Kode ICD	Deskripsi
414.0	A.H.D (atherosclerotic Heart Desease)
682	Other Cellulitis And Abcess
640.0	Abortus Imminens
637.9	Abortus Incomplitus
522.7	Periapical Abscess With Sinus
530.0	Achalasia And Cardiospasm
462	Acute Pharyngitis
308	Acute Reaction To Stress
295.4	Acute Schizophrenic Episode
463	Acute Tonsilitis
M.833	Adenoma Folikuler
617.0	Adenomyosis
568.0	Peritoneal Adhesions
614.2	Adnexitis
995.3	Allergi , Unspecified
995.2	Unspecified Adverse Effect Of Drug, Medicament ...
626.0	Amenorrhea Sekunder/primer
280	Anemia
413	Angina Pectoris
300.0	Anxiety, States
541	Appendicitis
427.9	Arhythmia Cordis
719.4	Arthralgia
716.9	Artritis, Kronik, Acut
789.5	Ascites
428.1	Asma Cardiale
799.0	Asphyxia
770.1	Aspirasi New Born
493.9	Asthma Brochiale, Status Asthmaticus
447.1	Atrial Insuffisiency (ai)
747.6	Atypical Distribution Vessel
279.4	Autoimmune Disease
616.8	Bartholinitis
765.1	Bblr
351.0	Bell's Palsy
767.1	Birth Injury
631	Blighted Ovum
466.1	Broncheolitis
490	Bronchitis
493.9	Bronchitis Asmatis
485	Bronchopneumoni
447.9	C.A.D (Coronary Artheri Diseases)
746.9	C.H.D (Congenital Heart Disease)
585	C.R.F (Chronic Renal Failure)
437.9	C.V.D (Cerebro Vascular Disease)
174.9	Cancer Mamae
680.4	Carbuncle / Furun Kulosis Hand
425.4	Cardiomyopathy
521.0	Caries Dental
366	Cataract
784.0	Cephalgia
343.9	Cerebral Palsy
786.5	Chest Pain
428.0	CHF (Congestive Heart Failure)
571.5	Chirrhosis Hepatic
575.1	Cholecystitis
M9100-3	Chorio Carcinoma
009.1	Colitis, Enteritis, Gastroenteritis

Tabel ICD / Diagnosa

Kode ICD	Deskripsi
948.1	Combustio 10 - 19 %
850	Commotio Cerebri
091.3	Condyloma
372.3	Conjunctivitis
564.0	Constipation
851.0	Contusio Cerebri
924.9	Contusion
923.5	Contusion Thumb
411	Coronary Insufficiency (acute)
930	Corpus Alienum Eye (Foreign Body)
616.2	Cyst Bartholion'gland
348.0	Cysta Brain
620.2	Cyste Ovary
595.9	Cystitis
429.9	Decomp Cordis
061	Dengue
692.9	Dermatitis
250.0	Diabetes Melitus
009.3	Diarhea/ Enteretis
836.5	Dislocation Knee
755.5	Distorsion Hand Bone
562.0	Diverticula Duodeni
009.0	Dysentery
625.3	Dysmenorrhea
536.8	Dyspepsia
786.0	Dyspnoea
633	Ectopic Pregnancy
457.0	Edemalympatic Due To Mastectomy
752.5	Ectopic Testis
345.9	Epilepsy
789.0	Episgastric Pain
784.7	Epistaxis
035	Erysipelas
919	Excoriation
780.3	Febris Konvulsi / Kejang Demam
780.6	Febris E/C Ignota Commoncold
079.9	Viral Infeksi
217	Fibroadenoma Mamae
565.0	Fissure Anus
487.1	Influensa
815	Fractur Hand
802.0	Fractur Nasal
823	Fractur Tibia & Fibula
801	Fracture Basal (Skull)
829	Fracture Bone
820.0	Fracture Collum Femure
825.2	Fracture Metatarsal
727.4	Ganglion
535	Gastritis
530.7	Gastrooesophageal Reflek
056.9	German Measles
E-906	Gigitan Binatang (kucing/anjing/monyet/tikus)
523	Gingival Periodontal Diseases
523.1	Gingivitis
641.9	Haemorrage Ante Partum
455.6	Hemorrhoids
228.0	Hemangioma Cavernosum
578.0	Hematemesis

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Tabel ICD / Diagnosa

Kode ICD	Deskripsi
599.7	Hematuria
666.1	Hemorrhage Post Partum-puerperal
070.3	Hepatitis B
571.4	Hepatitis Chronis Active
070.1	Hepatitis Type A
789.1	Hepatornegaly
550.9	Hernia Inguinalis,scrotalis
053.9	Herpes Zoster
722.0	HNP
373.1	Hordeolum
603.9	Hydrocele Testis
331.4	Hydrocephalus
773.1	Haemolytik Diseasedue To Abo Is
272.0	Hypercholesterinemia
643.0	Hyperemesis Gravidarum
401	Hypertensi
273.8	Hypoalbuminemia
251.2	Hypoglycaemia
458	Hypotension
300.1	Hysteria
656.4	I.U.F.D (Intra Uterin Fetal Death) Suspec
774.6	Icterus Neonatorum / Hyperbilirubinemia Neonatal
771.4	Infeksi Neonatus
079.9	Infeksi Viral
628	Infertelity Female
628.2	Infertility Of Tuba Origin
305.0	Intoxication Alcoholic
560.0	Invagination
724.3	Ischialgia
E-819	Kecelakaan Lalu Lintas
780.3	Kejang Demam
301	Kelainan Kepribadian
981	Keracunan Minyak Tanah
789.0	Kolik Abdomen
788.0	Kolik Uretra (Ginjal)
208.9	Leukemia
M8850	Lipoma
724.2	Low Back Pain, Lumbago
883	Luka Terbuka Dijari
017	Lymphadenitis (TBC Kelenjar)
084.6	Malaria
261	Marasmus
383	Mastoid & Peny. Pd Telinga
770.1	Meconium Aspiration Syndrome
578.1	Melena
626.2	Meno Metrorhagia, Menorraghia
V65.5	Menstruasi
626.6	Metrorrhagia
742.1	Microcephalus
346.9	Migraine
632	Missed Abortion
055.9	Morbilli
729.1	Myalgia & Myositis
117.9	Mycosis
410	Myocard Infark Acute
218	Myoma Uteri
729.1	Myositis
180.9	Neoplasm Cervix Uteri (Malignant)

Tabel ICD / Diagnosa

Kode ICD	Deskripsi
592.0	Neprolithiasis
729.2	Neuralgia
300.9	Neurosis State
V71.8	Observasi Condition
564.0	Obstipasi / Constipation
382.9	OMA
382.4	OMP
M.9180	Osteoma
379	Other Disorders Of Eye
537	Other Disorders Of Stomach And Duodenum
626.5	Ovulation Bleeding
263.9	P.C.M
785.1	Palpitation
577.0	Pancreatitis
344.9	Para Paresis
681.1	Paronchia Toe
427.0	Paroxismal Atrial Tachycardia
651	Partus Kembar
650	Partus Normal
652	Partus Sungsang
384.2	Perforation Membrana Tympani
033.9	Pertussis
472.1	Pharyngitis Kronis
605	Phimosis
111.0	Pityriasis Versicolor
511.9	Pleural Effusion
487.0	Influensa With Pneumonia
512	Pneumothorax
988.8	Poisoning Food
238.4	Polycythemia
011.9	Hemoptysis - KP
642.4	Pre Eclamsi
569.4	Proctitis
618.1	Prolapsus Uteri
698.9	Pruritis
306.9	Psikosomatik
298.9	Psychosis
296.9	Psychosis Affective
011	Pulmonary Tuberculosis (KP)
590 1	Pyelonephritis
426.4	RBBB (Right Bundle Branch Block)
518.5	RDS (Respiratory Distres Syndrom)
308.9	Reaction Stress Acute
770.8	Respiratory Distess After Birth
666.2	Retention Placenta Portion
729.0	Rheumatic
472.0	Rhinitis
460	Rhino Pharingitis
056.9	Rubella
614.2	Salpingitis
295.9	Schizophrenia
038.9	Septicemia
785.5	Shock Septic
461.0	Sinusitis Maxilaris
756.1	Spodylolisthesis
848.9	Sprain
493.9	Status Asthmaticus
528.0	Stomatitis

Tabel ICD / Diagnosa

Kode ICD	Deskripsi
780.2	Syncope
427.3	Syndrom Atrial Fibrilasi
E.812	Tabrakan Motor-mobil
785.0	Tachycardia
245.9	Thyroiditis Follicular
474.0	Tonsil Kronik
465.8	Tosilo Pharingitis
854.0	Trauma Capitis
E804	Trauma Tumpul
011.9	Tuberculosis Pulmonary
002	Typhoid And Paratyphoid Fever
599.0	U T I
707.9	Ulceration
707	Ulcus Chronic Of Skin
370.0	Ulcus Cornea
533.4	Ulcus Pepticum
592.0	Urethrolithiasis
592.9	Urolithiasis
465.9	URTI (Upper Respiratory Tractus Infk)
708.9	Urticaria
746.9	V.S.D (Ventricular Septal Defect)
616.1	Vaginitis
052	Varicella
454.9	Varicess
780.4	Vertigo
790.8	Viremia
079.9	Virus Infeksi
787.0	Vomiting
879.8	Vulnus, Scissum, Laceration, Ictium, Punctum
356.9	Polyneuropathy
715.9	Osteo Arthrosis
245.1	Sub Acute Thyroiditis
640	Haemorrhage In Early Pregnancy
813	Fracture Of Radius & Ulna
365.9	Glaucoma
785.4	Gangrene
715	Osteoarthrosis And Allied Disorders
506.2	Upper Respiratory Inflammation Due To Fumes+Vapour
580	Glomerulo Nephritis Acut
645	Gravida 40 - 44 Minggu
611.1	Hypertrophy Of Breast/Mastoplasia
573.3	Hepatitis
465	Acute Upper Respiratory Infections Of Multiple ...
540	Acute Appendicitis
424.1	Aortainsufficiency
065	Arthropod Borne Haemorragic Fever
607.1	Balanitis
112.0	Candidiasis Of Mouth
276.5	Dehydrasi
838	Dislocation Joint Foot Or Toe
831	Dislocation Of Shoullder
065.4	Dengue Haemorrhagic Fever (DHF)
E925	Kena Strom Listrik
394.0	Mitral Stenosis
581.9	Nephrotic Syndrom
380.2	Other Otitis Externa
644.1	Persalinan (37 Minggu)
487.1	Pharingitis Acut With Flu

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Tabel ICD / Diagnosa

Kode ICD	Deskripsi
308.0	Predominant Disturbance Of Emotions
8900/3	Rhabdomyosarcoma
781.7	Tetany
531	Ulcus Ventriculi
783.0	Anorexia
641.2	Premature Separation Of Placenta/Solution Placenta
439.9	Asthma Unspecified
511	Pleuritis
610.9	Mammary Dysplasia, Unspeciefed
535.0	Acute Gastritis
592.1	Batu Ureter
289.3	Lymphadenitis
366.1	Senile Cataract
V60.0	Transient
566	Abcess Of Annal Andrectal Regions
812.2	Fracture Humerus
471.9	Nasal Polyp
M880	Soft Tissue Tumours And Sarcomas Nos
656.3	Fetal Distress
229.8	Benign Neopiasm Other Specifiedsites
995.1	Angioneurotic Oedema
474	Chronic Disease Of Tonsils And Adenoids
455.6	Unspecified
622.7	Mucous Polyp Of Cervix
996.3	Mechanical Complication Of Genitourinary Device,..
M9180	Osteoma Liang Telinga
812.4	Fractura Supra Condilar Humeri
621.3	Endometrial Cystic Hyperplasia
342.9	Hemiplegia Unspecified
784.3	Aphasia
617.9	Endometriosis Site Unspecified
658.4	Infection Of Amniotic Cavity
745.0	A S D (Aortic Septal Defect)
331.9	Atrofie / Brain
615.9	Endometritis
634	Abortus Spontan / Complitus
762.0	Placenta Praevia
641.0	Placenta Praevia Without Haemorrhage
839.8	Luxatio/Dislocation
608.2	Torsion Testis
542	Appendicitis Chronic
757.3	Epidermolysis Bulosum
736.2	Kontraktur Jari Tangan
618	Hernia Vesica Urinaria
728.7	Fibromatosis Proliferative
474.1	Mypertrophya Of Tonsil & Adenoid
E950.6	Tentanmia Suidice
311	Depression
381.0	Otitis Media Sekretoria
786.2	Cough
574.1	Cholelithiasis & Cholecystitis Chronis
569.3	Haemorhagic Of Rectum And Anus
808.2	Fracture As Pubisdextra
473.0	Kronik Maxilaris Cirusitis
276.2	G E D
641.1	Placsa Previa Fatol
084.0	Malaria Falci Farum
292.9	Intoxitasi Muyadon

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Tabel ICD / Diagnosa

Kode ICD	Deskripsi
805.6	Fracrur Os Sacrum
652.2	Kelahiran Sungsang
471.8	Polip
620.0	Cystedenama Tyroid Sin
573.9	Other Disorders Of Liver On Unspecified
494	Bronciectsasi
246	Other Disorders Of Thyroid
816	Fracture Of One Or More Phalanges Of Hand
V22	Gravida Normal
427.8	Observasi Aritnea
802.8	Fracture Orbita
292.2	Pathological Drug Intoxication
931	Corpus Alienum Ear
932	Corpus Alienum Nose
935	Corpus Alienum In Mouth , ...
788.1	Dysuria
860.2	Hematoma Dinding Thorax
E928	Other & Unspecified Enviromental & Accidental ...
376	Oedema Palpebra
614.9	Pelvic Infection Or Inflamation Disease
481	Pneumonie Lobar
187.5	Malignant Neoplasim Of Epididymis
M8010/6	Carcinoma Metastatic Nos
528	Stamatitis
383.0	Abces Mastoid
382.3	Unspecified Ekromic Supprative Otitis Media
680.9	Furuwculosis
513.0	Abceslung
301.0	Paranoid
604.9	Orchitis
637	Abortus Complite
241.9	Struma Foelocularis Nodosa
600	Prostat
810	Fracture Of Clavicle
627.1	Postmenopausal Bleeding
284.9	Aplastic Anemia Unspecified
591	Hydronephrosis
005.9	Food Poisoing
522.0	Pulpitis
610.1	Fibrocystic Disease Of The Heart
057.8	Other Viral Exanthemata
653.0	Major Abnormality Of Bony Pelvis
763.4	Section Caesarian
766.2	NCO Lahir Spontan

Tabel Tindakan Pembedahan

Kode Tindakan	Deskripsi
5-010	Pungsi tengkorak (kranium)
5-011	Kraniotomi
5-012	Insisi Otak (ensefalon) & selaput otak (meninges)
5-013	Pembedahan talamus & globus palidus
5-014	Eksisi/destruksi otak (ensefalon) & meninges
5-015	Eksisi lesi tengkorak (kranium)
5-020	Kranioplasti
5-021	Reparasi selaput otak (meninges serebri)
5-022	Ventrikulostomi
5-023	Pirau bilik otak (ventrikulus serebri)
5-024	Revisi pirau bilik otak (ventrikulus serebri)
5-029	Pembedahan lain tengkorak, otak & meninges
5-030	Eksplorasi terusan sumsum tulang belakang
5-031	Pemisahan akar saraf spinal intraspinal
5-032	Kordotomi
5-033	Eksisi/destruksi sumsum belakang & meninges
5-034	Pembedahan plastik pd sumsum belakang & meninges
5-035	Pembebasan pelengketan sumsum belakang & akar sar.
5-036	Drainase spinal
5-037	Penyutikan bahan perusak ke dlm terusan sumsum blk
5-039	Pembedahan lain pd struktur sumsum belakang & ...
5-040	Pemutusan dan eksisi saraf
5-041	Destruksi saraf lain
5-042	Penjahitan saraf
5-043	Pembebasan perlengketan dan dekompresi saraf
5-044	Cangkokan saraf
5-045	Transposisi saraf
5-046	Neuroplasti lain
5-047	Penyuntikan ke dalam saraf
5-049	Pembedahan lain pada saraf otak dan saraf perifer
5-050	Pemutusan saraf simpatik atau simpul saraf
5-051	Simpatektomi
5-052	Penyuntikan ke dalam saraf simpatik / simpul saraf
5-053	Pembedahan lain pada saraf simpatik / simpul saraf
5-059	Pembedahan lain pada susunan saraf
5-060	Insisi daerah kelenjar gondok
5-061	Lobektomi kelenjar gondok sesisi
5-062	Tiroidektomi parsial lain
5-063	Tiroidektomi lengkap
5-064	Tiroidektomi substernum
5-065	Eksisi tiroid lidah
5-066	Eksisi saluran tiroglosus
5-067	Paratiroidektomi sebagian
5-068	Paratiroidektomi lengkap
5-069	Pembedahan lain pd kelenjar gondok & anak gondok
5-070	Eksplorasi anak ginjal
5-071	Adrenalektomi sebagian
5-072	Adrenalektomi dua sisi
5-073	Pembedahan lain pada anak ginjal
5-074	Pembedahan pada badan runjung
5-075	Hipofisektomi
5-076	Pembedahan lain pada hipofisis
5-077	Timektomi
5-078	Pencangkokan kacangan (timus)
5-079	Pembedahan lain pada kelenjar endokrin
5-080	Insisi kelenjar air mata (glandula lakrimalis)

Tabel Tindakan Pembedahan

Kode Tindakan	Deskripsi
5-081	Eksisi kelenjar air mata / jejas Dakrioadenektomi
5-082	Pembedahan lain pada kelenjar air mata
5-083	Pembuangan lesi saluran
5-084	Insisi saku air mata & saluran Drainase
5-085	Eksisi saku air mata / jejas Dakriokistektomi
5-086	Reparasi terusan air mata & titik air mata
5-087	Dakriokistorinostomi
5-088	Konjungtivorinostomi
5-089	Pembedahan lain pada sistem air mata
5-090	Insisi kelopak mata
5-091	Eksisi kelopak mata
5-092	Pembedahan pada sudut mata (kantus) dan tarsus
5-093	Koreksi entropion atau ektropion
5-094	Koreksi blefaroptosis
5-095	Blefarorafi
5-096	Reparasi lain kelopak mata
5-099	Pembedahan lain pada kelopak mata
5-100	Miotomi dan tenotomi otot mata
5-101	Eksisi otot mata / urat dg pemindahan insersi otot
5-102	Pemindahan insersi otot mata
5-103	Transposisi otot mata
5-104	Pemendekan lain otot mata
5-105	Pembebasan perlengketan otot mata
5-109	Pembedahan lain pada otot mata
5-110	Pembuangan benda asing dari konjungtiva dg insisi
5-111	Insisi lain konjungtiva
5-112	Eksisi lesi konjungtiva
5-113	Konjungtivoplasti
5-114	Membebaskan perlengketan konjungtiva & kelopak ..
5-115	Penjahitan konjungtiva
5-119	Pembedahan lain pada konjungtiva
5-120	Pembuangan magnetik benda asing dari kornea
5-121	Insisi kornea
5-122	Eksisi pterigium
5-123	Eksisi atau destruksi lesi kornea
5-124	Penjahitan kornea
5-125	Pencangkokan kornea
5-126	Reparasi lain kornea
5-129	Pembedahan lain pada kornea
5-130	Pembuangan benda asing dr segmen depan mata dg ins
5-131	Pembuangan magnetik benda asing dr segmen depan m
5-132	Mengurangi tekanan bola mata
5-133	Mempermudah sirkulasi intraokulus
5-134	Destruksi jejas iris, badan bulu / sklera
5-135	Iridektomi atau iridotomi lain
5-136	Iridoplasti
5-137	Skleroplasti
5-139	Pembedahan lain pd iris, badan bulu & kamar depan
5-140	Pembuangan magnetik benda asing dari lensa
5-141	Pembuangan benda asing dari lensa dg insisi
5-142	Ekstraksi linear lensa
5-143	Menyayat lensa dan simpai
5-144	Ekstraksi lensa ekstrakapsul
5-145	Ekstraksi lensa ekstrakapsul
5-146	Ekstraski lain katarak
5-147	Insersi lensa prostetik

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Tabel Tindakan Pembedahan

Kode Tindakan	Deskripsi
5-148	Pembuangan lensa prostetik tertanam
5-149	Pembedahan lain pada lensa
5-150	Pembuangan benda asing dr segmen blkg mata dg insi
5-151	Pembuangan megnetik benda asing dr segmen blkg mat
5-152	Skleral buckling dengan implantasi
5-153	Skleral buckling lain
5-154	Pembedahan lain untuk reparasi retina
5-155	Destruksi lesi retina atau koroid
5-156	Pembedahan lain pada retina atau koroid
5-157	Pembedahan pada badan bening (korpus vitreum)
5-160	Orbitomi
5-161	Pembuangan benda asing dari mata atau orbita ytd
5-162	Eviserasi bola mata
5-163	Pembuangan bola mata
5-164	Eksisi atau destruksi isi lekuk mata (orbita)
5-165	Insersi implan lekuk mata (orbita)
5-166	Pembuangan implan lekuk mata (orbita)
5-167	Reparasi lekuk mata (orbita)
5-169	Pembedahan lain pada lekuk mata (orbita) dan mata
5-180	Insisi telinga luar
5-181	Eksisi / destruksi lesi telinga luar
5-182	Eksisi lain telinga luar
5-183	Penjahitan telinga luar
5-184	Pembedahan koreksi kelainan telinga
5-185	Rekonstruksi liang telinga luar
5-186	Reparasi lain telinga luar
5-189	Pembedahan lain pada telinga luar
5-190	Mobilisasi sanggurdi (stapes)
5-191	Stapedektomi
5-192	Revisi stapedektomi
5-193	Pembedahan lain pada rantai tulang pendengar
5-194	Miringoplasti
5-195	Timpanoplasti lain
5-196	Revisi timpanoplasti
5-199	Reparasi lain telinga tengah
5-200	Miringotomi
5-201	Pembuangan tympanotomy tube
5-202	Insisi mastoid dan telinga tengah
5-203	Matoidektomi
5-204	Eksisi lain telinga tengah
5-205	Fenestrasi telinga dalam
5-206	Revisi fenestrasi
5-207	Insisi dan destruksi telinga dalam
5-209	Pembedahan lain pada telinga tengah & dalam
5-210	Penguasaan epistaksis
5-211	Insisi hidung
5-212	Eksisi atau destruksi lesi hidung
5-213	Reseksi hidung
5-214	Reseksi submukosa sekat hidung (Septum nasi)
5-215	Turbinektomi
5-216	Reposisi terbuka fraktur tulang hidung
5-217	Reparasi dan bedah plastik pada hidung
5-219	Pembedahan lain pada Hidung
5-220	Pungsi sinus hidung
5-221	Antrotomi intranasal

Tabel Instansi Induk

Kode	Deskripsi
01	Dep. Dalam Negeri
03	ABRI/Dep.Hankam
04	Dep. Kehakiman
13	DepDikBud
14	DepKes
39	Pemda Aceh
40	Pemda Sumut
41	Pemda Sumbar
42	Pemda Riau
43	Pemda Jambi
44	Pemda Sumsel
45	Pemda Bengkulu
46	Pemda Lampung
47	Pemda Jakarta
48	Pemda Jabar
49	Pemda Yogjakarta
50	Pemda Jateng
51	Pemda Jatim
52	Pemda Kalbar
53	Pemda Kalteng
54	Pemda Kalsel
55	Pemda Kaltim
56	Pemda Sulut
57	Pemda Sulteng
58	Pemda Sulsel
59	Pemda Sultra
60	Pemda Bali
61	Pemda NTB
62	Pemda NTT
63	Pemda Maluku
64	Pemda Irja
67	Pemda Timtim
81	Organisasi Islam
82	Organisasi Katholik
84	Organisasi Budha
85	Organisasi Hindu
86	Yayasan Sosial
87	Perusahaan (Swasta)
88	Perorangan
91	PN Perkebunan
92	Pertamina
93	Timah
95	Pelabuhan
96	Semen
97	Perusahaan Negara lain

Tabel Pangkat

Kode Pangkat	Deskripsi
4E	Pembina Utama
4D	Pembina Utama Madya
4C	Pembina Utama Muda
4B	Pembina Tingkat I
4A	Pembina
3D	Penata Tk.I
3C	Penata
3B	Penata Muda Tk.I
3A	Penata Muda
2D	Pengatur Tk.I
2C	Pengatur
2B	Pengatur Muda Tk.I
2A	Pengatur Muda
1D	Juru TK.I
1C	Juru
1B	Juru Muda Tk.I
1A	Juru Muda
01	Prada
02	Pratu
03	Kopda
04	Koptu
05	Serda
06	Sertu
07	Serka
08	Serma
09	Pelda
10	Peltu
11	Capa
12	Letda
13	Lettu
14	Kapten
15	Mayor
16	Letkol
17	Kolonel
18	Brigjen
19	Mayjen
20	Letjen
21	Jendral

Tabel Jabatan Fungsional / Profesi

Kode Profesi	Deskripsi
1.	TENAGA MEDIK
1.00	Dokter Umum
1.01	Dokter Asisten Ahli
1.02	Dokter Ahli Bedah
1.03	Dokter Ahli Penyakit Dalam
1.04	Dokter Ahli Anak
1.05	Dokter Ahli Obgin
1.06	Dokter Ahli Radiologi
1.07	Dokter Ahli Anesthesia
1.08	Dokter Ahli Patologi Klinik
1.09	Dokter Ahli Jiwa
1.10	Dokter Ahli Mata
1.11	Dokter Ahli THT
1.12	Dokter Ahli Kulit & Kelamin
1.13	Dokter Ahli Kardiologi
1.14	Dokter Ahli Paru
1.15	Dokter Ahli Saraf
1.16	Dokter Ahli Bedah Saraf
1.17	Dokter Ahli Bedah Orthopedi
1.18	Dokter Ahli Urologi
1.19	Dokter Ahli Patologi Anatomi
1.20	Dokter Ahli Patologi Forensik
1.21	Dokter Ahli Rehabilitasi Medik
1.22	Dokter Ahli Ahli Lainnya
1.23	Dokter Ahli Gigi
1.98	Dokter Gigi Ahli
2.	TENAGA PARAMEDIK PERAWATAN
2.01	Penata Rawat
2.02	Guru Perawat/Juru Bidan
2.03	Pengatur Rawat/Perawat Kes.
2.04	Bidan
2.05	Pengatur Rawat Jiwa
2.06	Pengatur Rawat Gigi
2.07	Pembantu Bidan(PK/E)
2.08	Juru Rawat PK U/C/D/A/B
3.	TENAGA PARAMEDIK NON PERAWATAN
3.01	Apoteker
3.02	Sarjana Farmasi
3.03	Psikologi
3.04	Sarjana Kesehatan Masyarakat
3.05	Dokter Hewan
3.06	Ahli Fisika Medik
3.07	Ahli Instalasi Medik
3.08	Penata Anestesi
3.09	Penata Fisiotherapi
3.10	Penata Rontgen
3.11	Penata Gizi
3.12	Penata Analis
3.13	Penilik Kesehatan
3.14	A T E M
3.15	Penata Catatan Medik
3.16	Speech Terapis
3.17	Occupational Terapis
3.18	Ortotis Prostetis
3.19	Pengatur Fisiotherapi
3.20	Pengatur Gizi

Tabel Jabatan Fungsional / Profesi

Kode Profesi	Deskripsi
3.21	Pengatur Analis
3.22	Asisten Apotheker
3.23	Pengatur Tehnik Gigi
3.24	Pembantu Penilik Hygiene
3.25	S P S A
3.26	Pekarya Kesehatan Atas
3.27	Pekarya Kesehatan Menengah
3.28	PK/F
3.29	PK/G
4.	TENAGA NON MEDIK
4.01	Sarjana Biologi
4.02	Sarjana Kimia
4.03	Sarjana Sarjana Antropologi
4.04	Sarjana Ekonomi
4.05	Sarjana Administrasi
4.06	Sarjana Hukum
4.07	Sarjana Teknik
4.08	Sarjana Kesejahteraan Sosial
4.09	Sarjana Akutansi
4.10	Sarjana Lainnya
4.11	Sarjana Muda Biologi
4.12	Sarjana Muda Kimia
4.13	Sarjana Muda Antropologi
4.14	Sarjana Muda Ekonomi
4.15	Sarjana Muda Administrasi
4.16	Sarjana Muda Hukum
4.17	Sarjana Muda Teknik
4.18	Sarjana Muda Kesejahteraan Sos
4.19	Sarjana Muda Statistik
4.20	Sarjana Muda Sekretaris
4.21	Sarjana Muda Lainnya
4.22	SMEA
4.23	STM
4.24	SKKA
4.25	SPMA
4.26	SMTA Lainnya
4.27	SMTP
4.28	SD Ke bawah

Tabel Status Penyelenggara RS

Kode	Deskripsi
10	Departemen Kesehatan
20	Pemda Propinsi
30	Pemda Kodya
40	Pemda Kabupaten
51	TNI AD
52	TNI AL
53	TNI AU
54	POLRI
61	Perkebunan
62	Pertamina
63	Timah
64	Aneka Tambang
65	Pelabuhan
66	Semen
67	Ditjen Pemasyarakatan
68	PUSRI/PELNI/dll
81	Organisasi/Islam
82	Organisasi/Katolik
83	Organisasi/Protestan
84	Organisasi/Budha
85	Organisasi/Hindu
86	Yayasan/Perkumpulan Sosial
87	Perusahaan
88	Perorangan

Tabel UPF

Kode UPF	Deskripsi	Jumlah Tempat Tidur				
		VIP	I	II	IIIA	IIIB
01	Penyakit Dalam	6	10	10	20	20
02	Bedah					
03	Kesehatan Anak					
04	Obstetri					
05	Ginekologi					
06	Bedah Saraf					
07	Saraf					
08	Jiwa					
09	T.H.T					
10	Mata	2	4	6	10	10
11	Kulit dan Kelamin	3	5	10	30	40
12	Gigi dan Mulut					
13	Kardiologi	5	5	10	15	15
14	Radioterapi/Kedokteran Nuklir	1	1	3	5	5
15	Bedah Orthopedi					
16	Paru-paru					
17	Kusta					
18	Umum	10	5	15	30	30
19	Unit Darurat					
20	Rehabilitasi Medis					
21	Isolasi					
22	Luka Bakar					
23	I.C.U					
24	I.C.C.U					
88	Perinatologi/Bayi					

Tabel Unit Rawat Jalan

Kode	Deskripsi	Hari Buka
01	**Penyakit Dalam**	7
01.A	Alergi/Immunologi	4
01.B	Endokrin	3
01.C	Gastro entrologi	0
01.D	Hepatologi	0
01.E	Netrologi	0
01.F	Psikomatik	0
01.G	Reumatologi	0
01.H	Hematologi	0
01.I	Pulmonologi	0
01.J	Kardiologi	0
02	**Bedah**	4
02.A	Orthopedi	0
02.B	Urologi	0
02.C	Kepala, leher, payudara	0
02.D	Plastik	0
02.E	Jantung	5
02.F	Anak	6
02.G	Vaskuler	2
02.H	Digestif	2
02.I	Tumor	2
03	**Kesehatan Anak**	3
03.A	Alergi/Immunologi	1
03.B	Endokrinologi	0
03.C	Gastro entrologi	2
03.D	Hematologi	0
03.E	THT	0
03.F	Kardiologi	0
03.G	Nefrologi	0
03.H	Neurologi	0
03.I	Perinatologi	0
03.J	Pulmonologi	0
03.K	Radiologi	2
03.L	Gizi	3
03.M	Akupungtur	0
03.N	Penyakit tropis	0
03.O	ICU	0
04	**Obstetri & Ginekologi**	3
04.A	Endokrinologi	0
04.B	Kesehatan Reproduksi	2
04.C	Onkologi	4
04.D	Perinatologi	2
04.E	Patologi/Sitologi	1
04.F	Urologi Wanita	5
05	**Keluarga Berencana**	3
06	**Bedah Syaraf**	3
06.A	Pediatrik	2
06.B	Vaskuler	2
06.C	Trauma	2
06.D	Saraf Perifer	1
06.E	Tumor	3
07	**Saraf**	2
07.A	Nyeri Kepala	1
07.B	C V D	1
07.C	Epilepsi	1
07.D	Neuro Oftalmologi	2
07.E	Echo Ensafalografi	2

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Tabel Unit Rawat Jalan

Kode	Deskripsi	Hari Buka
07.F	Trauma Kapitis	1
07.G	E M G	1
07.H	E E G	2
07.I	Neuro Psikologi	1
08	**Jiwa**	2
08.A	Anak dan Remaja	2
08.B	Dewasa	2
08.C	Narkotika dan Alkohol	2
09	**THT**	4
09.A	Neuro Otologi	1
09.B	Rhinologi	1
09.C	Onkologi	1
09.D	Otologi	2
09.E	Bronko Esofagologi	1
09.F	Laringo Faringologi	1
09.G	Bedah Plastik/Rekonstruksi	2
10	**Mata**	4
10.A	Glaukoma	1
10.B	Kornea	2
10.C	Refraksi	2
10.D	Strabismus	1
10.E	Neuro Oftalmologi	1
10.F	Retina	1
10.G	Tumor	2
10.H	Penyakit Segmen Anterior	1
10.I	Mata Anak	2
10.J	Trauma/Bedah Plastik	2
11	**Kulit & Kelamin**	5
11.A	Jamur	3
11.B	Sexually Transmited/Disease	1
11.C	Alergi Immunologi Kulit	1
11.D	Kosmetik Medik/Bedah Kulit	3
11.E	Kusta	1
11.F	Kulit Anak	2
11.G	Tumor Kulit	1
12	**Gigi & Mulut**	5
12.A	Kompersasi Gigi	2
12.B	Periodentologi	1
12.C	Bedah Mulut	2
12.D	Paramedicine	1
12.E	Prastodentia	1
12.F	Ilmu Pedodontia	1
13	**Kardiologi**	3
13.A	Jantung Bawaan	2
13.B	Jantung Rematik	1
13.C	Jantung Coroner	2
13.D	Jantung Hipertensil	2
13.E	Jantung Tropist/Miopatny	1
13.F	Bedah Jantung	1
13.G	Rehabilitasi	1
13.H	Laboratorium Non Invarsive	1
13.I	Laboratorium Invarsive	1
14	**Radiologi**	3
14.A	Radio diagnostik	1
14.B	Radio Therapi	1
14.C	Kedokteran Nuklir	2
15	**Bedah Orthopedi**	2

Tabel Unit Rawat Jalan

Kode	Deskripsi	Hari Buka
16	**Paru-Paru**	3
16.A	Infeksi	2
16.B	Onkologi	1
16.C	Asma	2
16.D	Paru Kerja	1
16.E	Darurat Gawat Paru	2
17	**Kusta**	2
18	**Umum**	6
18.A	N P K	1
18.B	Pejabat Teras	1
19	**Unit Darurat**	7
19.A	Bedah	1
19.B	Non Bedah	2
20	**Rehabilitasi Medik**	3
21	**Akupuntur Medik**	0
22	**Gizi**	1

Tabel Bangsal

Kode Bangsal	Deskripsi	Jumlah Tempat Tidur				
		VIP	I	II	IIIA	IIIB
01	Melati	10	0	0	0	0
02	Mawar	5	5	5	10	20
03	Anggrek	2	2	0	0	0
04	Anyelir	4	0	4	0	0
05	Dahlia	0	0	5	10	10
06	Cendrawasih	0	10	10	0	0
07	Cempaka	0	0	0	10	15
08	Seruni	0	0	4	8	16

Tabel Jaminan Kantor

Kode Kantor	Deskripsi
001	PT BERSAMA
002	PT BINTANG KEJORA
003	BANK KENARI
004	BANK LAUT BIRU
005	ASTER INDO MOBIL
006	PT LINGGA FURNITURE

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Tabel Agama

Kode	Deskripsi
1	Islam
2	Protestan
3	Roma Katolik
4	Hindu
5	Budha
6	Lain-lain

Tabel Cara Pembayaran

Kode	Deskripsi
1	Tunai
2	Sel. PHB
3	Jaminan Kantor
4	Angsuran
5	Fas./SKTM
6	M/K
7	Lain-lain

Tabel Cara Pasien Keluar RS

Kode	Deskripsi
1	Diizinkan Pulang
2	Dirujuk ke RS Lebih Tinggi
3	Dirujuk ke RS Lebih Rendah
4	Dirujuk ke Puskemas
5	Dirujuk ke Panti
6	Pindah ke RS Lain
7	Pulang Paksa
8	Lari
9	Lain-lain

Tabel Jenis Infeksi Nosokomial

Kode	Deskripsi
01	IN Saluran kencing tak bergejala
02	IN Saluran kencing bergejala
03	IN Saluran cerna
04	IN Saluran nafas bawah
05	IN Saluran nafas atas
06	IN Luka operasi pada kulit
07	IN Luka bakar
08	IN Lain pada kulit
09	IN Organ reproduksi
10	IN Bakteromia
11	IN Lainnya
99	Tidak tahu

Tabel Instansi yang Membayar Gaji

Kode	Deskripsi
1	SekJen. DepKes
2	DirJen. DepKes
3	KanWil. Depkes
4	Rumah Sakit
5	Instansi Lain

Tabel Sifat RS

Kode	Deskripsi
1	Sementara
2	Tetap

Tabel Jenis RS

Kode	Deskripsi
A	RS Umum
B	RS Jiwa
C	RS Bersalin
D	RS Mata
E	RS Kanker
F	RS Tuberkulosa Paru
G	RS Kusta
H	RS Karantina
I	RS Orthopedi & Prothese
J	RS Khusus Penyakit Dalam
K	RS Khusus Bedah
L	RS Jantung
M	RS Khusus THT
Y	RS Spesialis
Z	Rumah Bersalin

Tabel Cara Masuk RS

Kode	Deskripsi
1	RSU/RSK/RB
2	Puskesmas
3	Dokter/Dokter Gigi
4	Tenaga Paramedik
5	Kasus Polisi
6	Dukun Terlatih
7	Datang Sendiri

Tabel Pendidikan (Pasien)

Kode	Deskripsi
1	Tidak Sekolah
2	Belum/Tidak Tamat SD
3	Tamat SD
4	Tamat SMTP
5	Tamat SMTA
6	Tamat Universitas/Akademi

Tabel Prosedur Pasien Masuk RS

Kode	Deskripsi
1	Melalui Unit Darurat
2	Melalui Unit Rawat Jalan
3	Langsung Rawat Nginap

Tabel Radioterapi/Kedokteran Nuklir

Kode	Deskripsi
1	Cobalt, Cobalt Spheres & Microspheres
2	Cesium
3	Iridium
4	Tantalum
5	Strontum
7	Radium, Radium medles
8	Isotop Lainnya
I	Iodine
T	Pertechaste
P	Paosphorus
S	Sulfur
Z	Zinc
B	Bromine
R	Radionucline lainnya
9	Tidak jelas bahan yang dipergunakan

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Tabel Penyebab Infeksi Nosokomial

Kode	Deskripsi
1	Staphylococcus
2	Streptococcus
3	Pneumococcus
4	E. Coli
5	Kelbxiella
6	Pseudomonas
7	Proteus
8	Lain-lain
9	Tidak tahu

Tabel Keadaan Pasien Keluar

Kode	Deskripsi
1	Sembuh
2	Membaik
3	Belum sembuh
4	Mati < 48 Jam
5	Mati >= 48 Jam

Tabel Status Perkawinan

Kode	Deskripsi
1	Dibawah Umur
2	Belum Kawin
3	Kawin
4	Janda
5	Duda

Tabel Suku Bangsa

Kode	Deskripsi
1	Jawa
2	Sunda
3	Madura
4	Indonesia Lain
5	Asing

Tabel Status Ketenagaan

Kode	Deskripsi
1	Tenaga Tetap
2	Capeg
3	Tenaga Tidak Tetap (Part Time)
4	Honorer

Tabel Status Pegawai

Kode	Deskripsi
1	PNS Pusat (Depkes)
2	PNS DPK
3	PNS DPB
4	PNS Daerah
5	PNS P & K
6	ABRI
7	PNS Dep. Lain
8	Swasta

FORM OTORISASI

A. ENTRI TABEL

No.	Nama Tabel	Opr.			Sup.			Mgr.			Dir.		
		E	S	H	E	S	H	E	S	H	E	S	H
1	Data Inventarisasi RS												
2	Tarip Pelayanan												
3	Bangsal / Ruang												
4	Diagnosa / ICD												
5	Tindakan / Operasi												
6	Jaminan Kantor												
7	Jabatan Fungsional Karyawan RS												
8	Instansi Induk												
9	Pangkat Karyawan RS												
10	Status Penyelenggara RS												

B. ENTRI TRANSAKSI

No.	Nama Transaksi	Opr.			Sup.			Mgr.			Dir.		
		E	S	H	E	S	H	E	S	H	E	S	H
1	Registrasi Pasien Rawat Nginap												
2	Data Pasien Rawat Nginap												
3	Transaksi Pelayanan												
4	Data Karyawan RS												

Keterangan:

Opr : Operator
Sup : Supervisor
Mgr : Manager
Dir : Direktur

E : Entri
S : Simpan
H : Hapus

FORM OTORISASI

C. CETAK LAPORAN

No.	Nama Laporan	Opr.	Sup.	Mgr.	Dir.
A	RL				
1	RL 1 - Data Kegiatan RS				
2	RL 2b - Keadaan Morbiditas Pasien Rawat Nginap				
3	RL 3 - Data Inventarisasi				
4	RL 4 - Data Keadaan Ketenagaan RS				
5	RL 4a - Data Individual Ketenagaan RS				
B	BUKU REGISTER				
1	REG. 1 - Pendaftaran Pasien Rawat Jalan				
2	REG. 2 - Pelayanan Pasien Rawat Jalan				
3	REG. 3 - Pendaftaran Pasien Rawat Nginap				
4	REG. 4 - Pelayanan Pasien Rawat Nginap				
5	REG. 5 - Pembedahan				
6	REG. 6 - Persalinan dan Abortus				
7	REG. 7 - Pelayanan Diagnostik / Terapi				
8	REG. 8 - Penerimaan Spesimen Pasien				
9	REG. 9 - Kegiatan Pemeriksaan Laboratorium				
10	REG. 10 - Rujukan Dokter Ahli				
11	REG. 11 - Kunjungan Rumah				
C	SENSUS HARIAN				
1	Sensus Harian Pasien Rawat Nginap				
2	Rekapitulasi Sensus Harian Pasien Rawat Nginap				
D	BILLING / TAGIHAN				
1	Ringkasan Biaya Rawat Nginap				
2	Perincian Biaya Rawat Nginap				
3	Cetak Ulang Ringkasan Biaya Rawat Nginap				
4	Cetak Ulang Perincian Biaya Rawat Nginap				
5	Ringkasan Biaya Rawat Nginap (Periodik)				
6	Perincian Biaya Rawat Nginap (Periodik)				
7	Pasien Rencana Pulang				

Keterangan:
Opr : Operator
Sup : Supervisor
Mgr : Manager
Dir : Direktur

FORM OTORISASI

A. OPERATOR

No.	Nama	Kata Sandi	No.	Nama	Kata Sandi
1			11		
2			12		
3			13		
4			14		
5			15		
6			16		
7			17		
8			18		
9			19		
10			20		

B. SUPERVISOR

No.	Nama	Kata Sandi	No.	Nama	Kata Sandi
1			11		
2			12		
3			13		
4			14		
5			15		
6			16		
7			17		
8			18		
9			19		
10			20		

C. MANAGER

No.	Nama	Kata Sandi	No.	Nama	Kata Sandi
1			11		
2			12		
3			13		
4			14		
5			15		
6			16		
7			17		
8			18		
9			19		
10			20		