ALLIED HEALTH PROFESSIONALS COUNCIL



 MINISTRY OF HEALTH

P.O.BOX 7272, KAMPALA

TEL:0414345688,0776345688,0706345688

EMAIL: info@ahpc.ug; website: www.ahpc.ug

**CHECK LIST FOR THE MINIMUM REQUIREMENTS TO OPERATE A MEDICAL LABORATORY (Level 1)**

1. Name of the Medical Laboratory .................................………………………………………

2 Type of the laboratory (tick the appropriate)

* 1. Stand alone b) Under a Clinic/Hospital

c) If (b), Is the Clinic/Hospital licensed by any Health Professional Council? ...........................................

d) If (c) above is yes, state the Council.........................................................................................................

3**. Location**: District………………..................... County………………………....................................

Sub-county……..……………….................... **LC**1/street…………………………............................

Postal address…………………..email…….............................................................………………….

 Phone (s) Landline……………….………………Mobile…………………………….……………….

4. Is the Laboratory registered with the AHPC? Yes No If yes, Reg. No……….………

5. Personnel inventory.

|  |  |  |
| --- | --- | --- |
| **PERSONNEL** | **NAME** | **QUALIFICATION(use a tick to indicate the qualification)** |
| Degree | Diploma | Certificate | Others qualifications |
| **In-charge** |  |  |  |  |  |
| **Others (including part time)** |  |  |  |  |  |
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|  |  |  |  |  |
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|  |  |  |  |  |

6. Contact person’s Name…............................................... Sign .......…………Tel….............................

**Level 1**

|  |  |  |  |
| --- | --- | --- | --- |
| **S/N** | **Tests performed** | Yes / No | Comments |
| 1 | Syphilis screening (RPR/VDRL) |  |  |
| 2 | HIV Serology (Rapid tests) |  |  |
| 3 | Pregnancy test (Rapid or hCG) |  |  |
| 4 | Blood glucose  |  |  |
| 5 | Haemoglobin estimation  |  |  |
| 6 | Erythrocyte Sedimentation Rate (ESR) |  |  |
| 7 | Urine microscopy |  |  |
| 8 | Urine dipstick |  |  |
| 9 | Stool microscopy |  |  |
| 10 | Blood slide for malaria or other blood parasites |  |  |
| 11 | Sickle cell screening test |  |  |
| 12 | Wet preparation mounts |  |  |
| 13 | Gram staining |  |  |
| 14 | ZN staining  |  |  |
| 15 | ABO and Rhesus grouping |  |  |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **S/NO** | **PHYSICAL SPACE**  | **YES/NO** | **COMMENTS** |
| 1 | Testing area – 6 sq meters (minimum)  |  |  |
| 2 | Phlebotomy to fit a coach with an arm chair  |  |  |
| 3 | Lighting (Natural /Artificial) |  |  |
| 4 | Ventilation (Sufficient / Insufficient) |  |  |
| 5 | Reception and Waiting area (sufficient) |  |  |
| 6 | Patient’s Toilet |  |  |
| 7 | Storage area for: |  |  |
| Lab reagents |  |  |
| Supplies |  |  |
| Records |  |  |
| 8 | Source of running water |  |  |
| 9 | Wash hand basin |  |  |
| 10 | Fire extinguisher |  |  |
| 11 | Separate room if doing Ziehl-Neelsen staining |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **S/NO** | **EQUIPMENT AND MATERIALS** | **YES / NO** | **COMMENTS** |
| 1 | Binocular microscope |  |  |
| 2 | Calorimeter with required filters or Haemoglobinometer |  |  |
| 3 | Glucometer |  |  |
| 4 | Appropriate strips for tests performed |  |  |
| 5 | Appropriate stains |  |  |
| 6 | Staining containers or rack |  |  |
| 7 | Waste containers |  |  |
| 8 | Centrifuge |  |  |
| 9 | ESR rack, tubes and timer |  |  |
| 10 | Immersion Oil  |  |  |
| 11 | Microscope slides and glass cover slips |  |  |
| 12 | Disinfectants and Antiseptics |  |  |
| 13 | Work bench |  |  |
| 14 | Protective wear (coat, gloves, etc) |  |  |
| 15 | Record books (Phlebotomy, Results and sample referrals) |  |  |
| 16 | SOPs for tests being performed |  |  |
| 17 | Appropriate specimen containers (stool, urine, blood, etc) |  |  |
| 18 | Refrigerator |  |  |

District Laboratory Focal Person’s general comments

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………....District Laboratory Focal Person’s Name …………………………..Signature…………………Date..............

Lab In-charge’s Name………………………………Signature…………………Date………………………

Recommendations of DHO

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………....

Signed: ……………………………………………………………………………………………………......

Full Names: ………………………………………………………………………………………….……….

Dated: ………………………………………………………………………………………………………….

Official stamp/Seal

**FOR OFFICIAL USE ONLY**

Comments

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Signed...............................................................

Full names...........................................................................................................................................................

Title.....................................................................................................................................................................

Date...............................................................