

CHAPTER 32

Content of Unit Health Record: Clinic / Sick Call / Outpatient

I. POLICY

The unit health record (UHR) must contain sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the results accurately. The ambulatory care health record serves as a basis for planning patient care and for continuity in the evaluation of the patient's condition. The content of the ambulatory care health record must adequately document communication between responsible providers, and any other health professional contributing to the care of the patient. It also protects the legal interests of the patient, the health facility, and provider.

The printout of a computerized record shall be accepted as the original. These documents, which have been authenticated electronically, do not require additional signatures.

II. PROCEDURE

For each visit, or personal encounter for ambulatory services, the health care practitioner shall document the following in the patient UHR:

A. Identification data including, but not limited to, the following:

1. Name.
2. Patient identification number.
3. Date of birth.
4. Date and time of visit.
5. Place of encounter.

B. Clinician information using the S.O.A.P.E. format including, but not limited to, the following:

1. Subjective - the patient's chief complaint, or purpose of/reason for the visit.
2. Objective - clinical findings such as the evidence of tests and observations.
3. Assessment - initial diagnostic impression based on the evidence, and the evaluator's judgment.
4. Plan - the course of treatment or services chosen.

C. Past medical services provided pertinent to the visit, including Emergency Room report (if applicable).

D. Physician's orders for medication, activity, treatment, testing, evaluation, consultation, dietary supplements to the standard meals, or other services.

E. Dated, timed, and signed health care notes including, but not limited to, the following:

1. Progress notes including the patient's response to medication and treatment rendered and observation(s) of the patient by all members of treatment team providing services to the patient.
2. Documentation of medication given including name, dosage, and time of administration of medications, and treatment given. The route of administration and site of injection shall be recorded if other than by oral administration.
3. Vital signs including weights.
4. Records of all laboratory tests ordered, initialed and dated by a CDC physician. Abnormal results shall be documented in the progress notes along with documentation that the physician counseled the patient regarding abnormal result and treatment plan.
5. Reports of all cardiographic or encephalographic tests performed.
6. Reports of all X-ray examinations ordered.
7. All reports of special studies ordered.
8. Consent forms as required, signed by the patient or the appropriate surrogate decision maker including Consent for Surgical, Special Diagnostic, or Therapeutic Procedures, and consents for psychotropic medications.
9. Consultation reports, if applicable.
10. All dental records, if applicable to the ambulatory visit.
11. Obstetrical records, if applicable to the ambulatory visit.
12. Final diagnosis or impression.
13. Discharge or transfer information, any dietary counseling provided, and continuing care instructions.