CHAPTER 34

Content of Unit Health Record (UHR): Ambulatory Surgery

I. POLICY

The UHR must contain sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the results accurately. The UHR in the ambulatory surgery setting serves as a basis for planning patient care and for continuity in the evaluation of the patient's condition. The content of the UHR 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

A. Each health record for ambulatory surgery services shall consist of at least the following:
B. Identification data including, but not limited to, the following:
   1. Name.
   2. Patient identification number.
   3. Date of birth.
   4. Sex.
   5. Marital status.
   6. Religion (optional on part of the patient).
   7. Date of visit.
   8. Name of institution responsible for the patient's treatment.
   9. Name of attending physician/surgeon.
   10. Initial diagnostic impression.
   11. Name of procedure(s) performed.
   12. Disposition.
   13. Discharge or final diagnosis.
C. Emergency Room report (if applicable), which includes arrival information, chief complaint, objective findings, diagnosis, treatment, outcome, and disposition. [CDC Form 7286]
D. Surgical Consent form. [CDC Form 7204]
E. History and physical to be completed prior to surgery. A history and physical completed within 30 days prior to surgery may be used. If the examination was conducted more than 5 days prior to surgery, any clinical changes or lack of changes must be noted. [CDC Form 7206]

F. Pre-operative and Post-operative Anesthesia notes, dated and signed. Discharge note shall include a physician evaluation at the time of release if general anesthesia or sedation was used.
G. Anesthesia Record completed and signed by Anesthesiologist.
H. Operative Report or Procedure Note.
I. Pathology Report, if applicable.
J. Operating Room/ Recovery Room Record.
K. Dated, timed, and signed observations and progress notes using the S.O.A.P.E. format, including any complications encountered, working diagnosis, by the person responsible for the care of the patient. There must be a progress note written for each clinician visit.
L. Physician's orders for admission, activity, medication, treatment, diet, discharge, or other services.
M. Dated, timed, and signed health care note to include discharge or transfer information and continuing care instructions.