

## **449.989 Medical records: Contents**

The medical record of each patient must be complete, authenticated, accurate and current, and must include the following information:

**1.**

A complete identification of the patient, including information on his or her next of kin and on the person or agency legally or financially responsible for him or her.

**2.**

A statement concerning the admission and diagnosis of the patient.

**3.**

The medical history of the patient.

**4.**

Documentation that the patient has been given a: (a) Physical examination, which must include a medical history of the patient, conducted by a physician within the 30 days immediately preceding the date of the patient's surgery; and (b)

Presurgical evaluation conducted by a physician or a podiatric physician licensed pursuant to chapter 635 of NRS, as applicable, on the day of the patient's surgery or within the 7 days immediately preceding the date of the patient's surgery.

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Physical examination, which must include a medical history of the patient, conducted by a physician within the 30 days immediately preceding the date of the patient's surgery; and

**(b)**

Presurgical evaluation conducted by a physician or a podiatric physician licensed pursuant to chapter 635 of NRS, as applicable, on the day of the patient's surgery or within the 7 days immediately preceding the date of the patient's surgery.

**5.**

Evidence of any informed consent given for the care of the patient.

**6.**

Any clinical observations of the patient, such as the notes of a physician, a nurse or any other professional person in attendance. Such an entry must be signed by the person making the entry and include the title of that person.

**7.**

Reports of all studies ordered, including laboratory and radiological examinations.

**8.**

Confirmation of the original diagnosis, or the diagnosis at the time of discharge.

**9.**

A report of any surgery performed on the patient, prepared by the surgeon.

**10.**

A description of the procedure followed in any administration of anesthesia to the patient.

**11.**

A recovery report for the patient.

**12.**

A summary of discharge, including, without limitation, the disposition of the patient and any recommendations and instructions given to the patient.

**13.**

Documentation that a member of the nursing staff interviewed the patient within

72 hours after the patient was discharged from the center to determine the condition of the patient and whether the patient was satisfied with the services provided, and to receive any complaints or problems the patient may have.