449.61156 Medical records: Contents

The medical record of a patient which is on file with the obstetric center must be completed, authenticated, accurate and current, and must include:

1.

A complete identification of the patient including information about the next of kin of the patient and the person or agency legally or financially responsible for the patient.

2.

A statement concerning the admission and diagnosis of the patient.

3.

The medical history of the patient.

4.

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

5.

Any clinical observation of the patient, including, but not limited to, the notes of all clinical staff in attendance.

6.

A report of all prescribed tests and examinations.

7.

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

8.

A summary of discharge prepared in accordance with the established policy of the obstetric center, and any provisions made for continuing care or follow-up of the patient after discharge.

9.

If the patient has died while under the care of the obstetric center, documentation of the death which must be signed by a physician .