CA

70527 Outpatient Service General Requirements

(a)

Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.

(b)

The responsibility and the accountability of the outpatient service to the medical staff and administration shall be defined.

(c)

If outpatient surgery is performed, the written policies and procedures shall make provision for at least the following:(1) The types of operative procedures that may be performed. (2) Types of anesthesia that may be used. (3) Preoperative evaluation of the patient, meeting the same standards as apply to inpatient surgery. (4) Informed operative consent. (5) The delivery of all anatomical parts, tissues and foreign objects removed to a pathologist designated by the hospital and a report of findings to be filed in the patient's medical record. (6) Written preoperative instructions to patients covering: (A) Applicable restrictions upon food and drugs before surgery. (B) Any special preparations to be made by the patient. (C) Any postoperative requirements. (D) An understanding that admission

to the hospital may be required in the event of an unforeseen circumstance. (7) Examination of each patient by a licensed practitioner whose scope of licensure permits prior to discharge.

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(B)

Any special preparations to be made by the patient.

(C)

Any postoperative requirements.

(D)

An understanding that admission to the hospital may be required in the event of an unforeseen circumstance.

(7)

Examination of each patient by a licensed practitioner whose scope of licensure permits prior to discharge.

(d)

A medical record shall be maintained for each patient receiving care in the outpatient service. The completed medical record shall include the following, if applicable: (1) Identification sheet to include but not be limited to the following patient information: (A) Name. (B) Address. (C) Identification number (if applicable). 1. Hospital number. 2. Social Security. 3. Medicare. 4. Medi-Cal. (D) Age. (E) Sex. (F) Marital status. (G) Religious preference. (H) Date and time of arrival. (I) Date and time of departure. (J) Name, address and telephone number of person or agency responsible for the patient. (K) Initial diagnostic impression. (L) Discharge or final diagnosis. (2) Medical history including: (A) Immunization record. (B) Screening tests. (C) Allergy record. (D) Nutritional evaluation. (E) Neonatal history for pediatric patients. (3) Physical examination report. (4) Consultation reports. (5) Clinical notes including dates and time of visits. (6) Treatment and instructions, including: (A) Notations of prescriptions written. (B) Diet instructions, if applicable. (C) Self-care instructions. (7) Reports of all laboratory tests performed. (8) Reports of all X-ray examinations performed. (9) Written record of preoperative and postoperative instructions. (10) Operative report on outpatient surgery including preoperative and postoperative diagnosis, description of findings, techniques used and tissue removed or altered, if

appropriate. (11) Anesthesia record including preoperative diagnosis, if anesthesia is administered. (12) Pathology report, if tissue or body fluid was removed. (13) Clinical data from other providers. (14) Referral information from other agencies. (15) All consent forms.

(1)

Identification sheet to include but not be limited to the following patient information: (A) Name. (B) Address. (C) Identification number (if applicable). 1. Hospital number. 2. Social Security. 3. Medicare. 4. Medi-Cal. (D) Age. (E) Sex. (F) Marital status. (G) Religious preference. (H) Date and time of arrival. (I) Date and time of departure. (J) Name, address and telephone number of person or agency responsible for the patient. (K) Initial diagnostic impression. (L) Discharge or final diagnosis.

(A)

Name.

(B)

Address.

(C)

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(D)

Age.

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Marital status.

(G)

Religious preference.

(H)

Date and time of arrival.

(I)

Date and time of departure.

(J)

Name, address and telephone number of person or agency responsible for the patient.

(K)

Initial diagnostic impression.

(L)

Discharge or final diagnosis.

(2)

Medical history including: (A) Immunization record. (B) Screening tests. (C) Allergy record. (D) Nutritional evaluation. (E) Neonatal history for pediatric patients.

(A)

Immunization record.

(B)

Screening tests.

(C)

Allergy record.

(D)

Nutritional evaluation.

(E)

Neonatal history for pediatric patients.

(3)

Physical examination report.

(4)

Consultation reports.

(5)

Clinical notes including dates and time of visits.

(6)

Treatment and instructions, including: (A) Notations of prescriptions written. (B) Diet instructions, if applicable. (C) Self-care instructions.

(A)

Notations of prescriptions written.

(B)

Diet instructions, if applicable.

(C)

Self-care instructions.

(7)

Reports of all laboratory tests performed.

(8)

Reports of all X-ray examinations performed.

(9)

Written record of preoperative and postoperative instructions.

(10)

Operative report on outpatient surgery including preoperative and postoperative diagnosis, description of findings, techniques used and tissue removed or altered, if appropriate.

(11)

Anesthesia record including preoperative diagnosis, if anesthesia is administered.

(12)

Pathology report, if tissue or body fluid was removed.

(13)

Clinical data from other providers.

(14)

Referral information from other agencies.

(15)

All consent forms.

(e)

Periodically, an appropriate committee of the medical staff shall evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration.