70749 Patient Health Record Content

(a)

Each inpatient medical record shall consist of at least the following items: (1) Identification sheets which include but are not limited to the following: (A) Name. (B) Address on admission. (C) Identification number (if applicable). 1. Social Security. 2. Medicare. 3. Medi-Cal. (D) Age. (E) Sex. (F) Martial status. (G) Religion. (H) Date of admission. (I) Date of discharge. (J) Name, address and telephone number of person or agency responsible for patient. (K) Name of patient's admitting licensed health care practitioner acting within the scope of his or her professional licensure. (L) Initial diagnostic impression. (M) Discharge or final diagnosis. (2) History and physical examination. (3) Consultation reports. (4) Order sheet including medication, treatment and diet orders. (5) Progress notes including current or working diagnosis. (6) Nurses' notes which shall include but not be limited to the following: (A) Concise and accurate record of nursing care administered. (B) Record of pertinent observations including psychosocial and physical manifestations as well as incidents and unusual occurrences, and relevant nursing interpretation of such observations. (C) Name, dosage and time of administration of medications and treatment. Route of administration and site of injection shall be recorded if other than by oral administration. (D) Record of type of restraint and time of application and removal. The time of application and removal shall not be required for soft tie restraints used for support and protection

of the patient. (7) Vital sign sheet. (8) Reports of all laboratory tests performed. (9) Reports of all X-ray examinations performed. (10) Consent forms, when applicable. (11) Anesthesia record including preoperative diagnosis, if anesthesia has been administered. (12) Operative report including preoperative and postoperative diagnoses, description of findings, technique used, tissue removed or altered, if surgery was performed. (13) Pathology report, if tissue or body fluid was removed. (14) Labor record, if applicable. (15) Delivery record, if applicable. (16) A discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, his condition on discharge and the recommendations and arrangements for future care.

(1)

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(A)

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(B)

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(C)

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

(K)

Name of patient's admitting licensed health care practitioner acting within the scope of his or her professional licensure.

(L)

Initial diagnostic impression.

(M)

Discharge or final diagnosis.

(2)

History and physical examination.

(3)

Consultation reports.

(4)

Order sheet including medication, treatment and diet orders.

(5)

Progress notes including current or working diagnosis.

(6)

Nurses' notes which shall include but not be limited to the following: (A) Concise and accurate record of nursing care administered. (B) Record of pertinent observations including psychosocial and physical manifestations as well as incidents and unusual occurrences, and relevant nursing interpretation of such observations. (C) Name, dosage and time of administration of medications and treatment. Route of administration and site of injection shall be recorded if other than by oral administration. (D) Record of type of restraint and time of application and removal. The time of application and removal shall not be required for soft tie restraints used for support and protection of the patient.

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Concise and accurate record of nursing care administered.

(B)

Record of pertinent observations including psychosocial and physical manifestations as well as incidents and unusual occurrences, and relevant nursing interpretation of such observations.

(C)

Name, dosage and time of administration of medications and treatment. Route of administration and site of injection shall be recorded if other than by oral administration.

(D)

Record of type of restraint and time of application and removal. The time of application and removal shall not be required for soft tie restraints used for support and protection of the patient.

(7)

Vital sign sheet.

(8)

Reports of all laboratory tests performed.

(9)

Reports of all X-ray examinations performed.

(10)

Consent forms, when applicable.

(11)

Anesthesia record including preoperative diagnosis, if anesthesia has been administered.

(12)

Operative report including preoperative and postoperative diagnoses, description of findings, technique used, tissue removed or altered, if surgery was performed.

(13)

Pathology report, if tissue or body fluid was removed.

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Labor record, if applicable.

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Delivery record, if applicable.

(16)

A discharge summary which shall briefly recapitulate the significant findings and

events of the patient's hospitalization, his condition on discharge and the recommendations and arrangements for future care.