97560.1 Patient Data

Each facility shall maintain, on forms provided by the Office, those patient data and other patient information required by the Office which shall include, but need not be limited to, the following:

(1)

For each patient, a Discharge Abstract Data Record which includes all of the items set forth in Health and Safety Code section 443.31(g). This information shall include procedures and diagnoses relating to the outpatient surgery the patient received prior to admission to the facility.

(2)

For each patient, a record which shows the: (A) Planned length of stay. (B) Actual length of stay.

(A)

Planned length of stay.

(B)

Actual length of stay.

(3)

For any patient who stays longer than 48 hours, the following shall be listed: (A) The reason for the additional stay. (B) The reason it was not originally anticipated.

(A)

The reason for the additional stay.

(B)

The reason it was not originally anticipated.